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ABSTRACT

Almost every school has had a major crisis; every school is likely to have one. Some students react with severe emotional responses--fear, grief, post traumatic stress syndrome. Moreover, such experiences and other events that threaten their sense of worth and well-being can produce the type of intense personal turmoil that leads students to think about hurting themselves or others. If no effort is made to intervene, emotional reactions may interfere with a student's school and home performance, can be imminently life threatening, or may be the start of long-term psychosocial problems. When a significant portion of the student body is affected, major facets of a school's functioning are likely to be jeopardized. This training tutorial is designed with self-directed opportunities for more in-depth learning about the specific topic of crisis assistance and prevention. It contains resources providing easy access to a wealth of organized content and tools that can be used as a self-tutorial or as a guide in training others. The tutorial is organized topically, with readings and related activities for preparation, active learning, and follow-up. (GCP)

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A Center Training Tutorial . . .

Training Tutorial

CRISIS ASSISTANCE & PREVENTION: REDUCING BARRIERS TO LEARNING

This document is a hardcopy version of a resource that can be downloaded at no cost from the Center's website http://smhp.psych.ucla.edu.

This Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspice of the School Mental Health Project, Dept. of Psychology, UCLA. Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563 (310) 825-3634 Fax: (310) 206-8716; E-mail: smhp@ucla.edu
Website: http://smhp.psych.ucla.edu

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

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Mental Health in Schools Center

Training and Technical Assistance

The *Center for Mental Health in Schools* operates under the auspices of the School Mental Health Project at UCLA.* It is one of two *national centers* concerned with mental health in schools that are funded in part by the U.S. Department of Health and Human Services, Office of Adolescent Health, Maternal and Child Health Bureau, Health Resources and Services Administration -- with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration (Project #U93 MC 00175).

The UCLA Center approaches mental health and psychosocial concerns from the broad perspective of addressing barriers to learning and promoting healthy development. In particular, it focuses on comprehensive, multifaceted models and practices to deal with the many external and internal barriers that interfere with developrnent, learning, and teaching. Specific attention is given policies and strategies that can counter marginalization and fragmentation of essential interventions and enhance collaboration between school and community programs. In this respect, a major emphasis is on enhancing the interface between efforts to address barriers to learning and prevailing approaches to school and community reforms.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

CMHS
Center for Mental Health Services
SAMHSA
Substance Abuse & Mental Health Services Administration

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Continuing Education Modules & Training Tutorials: Self-directed opportunities to learn

In addition to offering *Quick Training Aids*, the Center's *Continuing Education Modules* and *Training Tutorials* are designed as self-directed opportunities for more in-depth learning about specific topics. These resources provide easy access to a wealth of planfully organized content and tools that can be used as a self-tutorial or as a guide in training others. As with most of our resources, these can be readily downloaded from our website - http://smhp.psych.ucla.edu - see Center Materials and scroll down to VI.

In the coming years, the Center will continue to develop a variety of continuing education modules and training tutorials related to the various topics covered by our Clearinghouse. In all its work, the Center tries to identify resources that represent "best practice" standards. We invite you to browse through this first set of modules and tutorials, and if you know of better material, please provide us with feedback so that we can make improvements.

CONTINUING EDUCATION MODULES

- *Addressing Barriers to Learning: New Directions for Mental Health in Schools*
- *Mental Health in Schools: New Roles for School Nurses*
- *Enhancing Classroom Approaches for Addressing Barriers to Learning: Classroom-Focused Enabling* (has an accompanying set of readings & tools)

TRAINING TUTORIALS

- *Classroom Changes to Enhance and Reengage Students in Learning*
- *Support for Transitions*
- *Home involvement in Schooling*
- *Community Outreach*
- *Crisis/Emergency Assistance and Prevention*
- *Student and Family Assistance*
- *Creating an infrastructure for an Enabling (Learning Support) Component to address barriers to student learning*

Using the Modules and Tutorials to Train Others

A key aspect of building capacity at schools involves ongoing staff and other stakeholder learning and development.* Those who are responsible for facilitating the training of others can use the Center's Continuing Education Modules and Training Tutorials to upgrade their repertoire and as resources in providing stakeholder training opportunities. With respect to training others, below are a few general reminders.

- *Start where they're at.* Good learning and teaching experiences are built on the concept of a good "match" (or "fit"). This involves both capabilities *and* interest (e.g., motivational readiness). From this perspective, it is essential to work with learner perceptions about what they want to learn and how they want to learn it. Thus, you might begin by finding out from those at the school:

  ✓ What are their most pressing concerns (e.g., what range of topics are of interest, and within a broad topic, what subtopics would be a good starting point)?

  ✓ How deeply do they want to cover a given subject (e.g., brief overview or in-depth)?

  ✓ How would they like to organize learning opportunities?

  Also, in terms of a good match, it is invaluable to capitalize on "teachable moments." Occurrences frequently arise at a school that result in the need for staff to learn something quickly. These teachable moments provide opportunities to guide staff to the type of resources included in the Continuing Education Modules and Training Tutorials. These resources can be drawn upon to create displays and provide handouts and then following-up by engaging staff in discussions to explore relevant experiences and insights.

- *"Preheat" to create interest.* Do some "social marketing." Put up some displays; provide prospective learners with a few interesting fact sheets; hold a brief event that focuses on the topic.

- *Active Learning.* Although reading is at the core of the modules and tutorials, active learning and doing is essential to good learning. Active learning can be done alone or in various group configurations. The point is to take time to think and explore. Study groups can be a useful format. Individual and group action research also provides application opportunities.

- *Follow-up for ongoing learning.* Provide information on resources for ongoing learning. Plan ways to offer follow-up discussions and exploration in general and in personalized ways with those who want and need more.

*There is a great deal of material discussing ways to pursue effective staff development in schools. An organization that is devoted to this arena is the National Staff Development Council (NSDC). It's library of information (see – http://www.nsdc.org/educatorindex.htm) provides guidelines, tools, and access to the *Journal of Staff Development*. The organization's emphasis is on a "how-to" format, offering a variety of effective, step-by-step models developed by practitioners who base their methods on research and real-world experiences.

TRAINING TUTORIAL

The Center's Training Tutorials are organized topically, with readings and related activities for "preheating," active learning, and follow-up. All readings and activity guides are available on the website of the national *Center for Mental Health in Schools* at UCLA.

http://smhp.psych.ucla.edu

CRISIS ASSISTANCE AND PREVENTION: REDUCING BARRIERS TO LEARNING

Overview Guide

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>School-Based Crisis Intervention (From: *Responding to a Crisis at a School* pp. 5-8 in original document)	2
>*Youth Suicide/Depression/Violence* (newsletter article)	7
>*Responding to and Preventing Crises and their Impact* (Tutorial flyer)	14

Learning Sessions

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Topic 1:	***Reducing the impact on crises through preparedness.***	15
Reading.	From: *Responding to a Crisis at a School, "Some Key Considerations in Establishing a System for School-Based Crisis Response" (pp. 17-27 in original document)*	16
Activity.	Use the various attached materials as stimuli and tools to focus application of what has been read	
	(1) *Outline What Has Been Learned so Far* - Develop a brief outline of what you have learned about how schools can reduce the im pact of crises by preparing to respond. (use the attached work sheet)	28
	(2) *Discussion Session Exploring What Has Been Outlined* – Form an informal discussion and/or a formal study group (see the attached guide.)	29
	(3) *Outline revision* – Make ongoing revisions in the outline (use the attached guide)	30
	(4) *Review the self study survey entitled:* Crisis Assistance and Prevention (attached)	31

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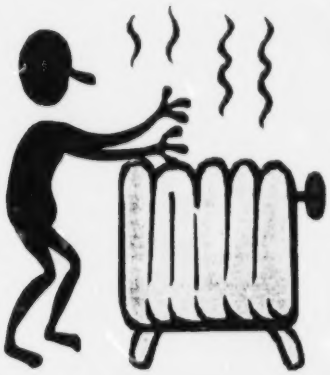
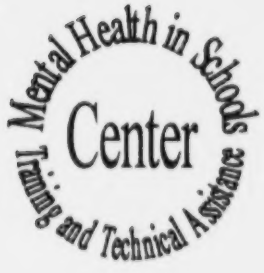
Initial Resources to "Preheat" Exploration of this Matter

The following materials provide a brief introduction and overview to the ideas covered by the tutorial:

	Page
School-Based Crisis Intervention (From: *Responding to a Crisis at a School* pp. 5-8 in original document)	2
Youth Suicide/Depression/Violence (newsletter article) To view this and other newsletter editions online visit http://smhp.psych.ucla.edu/news.htm	7
In readying others for training in this matter, display the attached flyer and the above article on a training bulletin board and provide copies to interested staff.	
Responding to and Preventing Crises and their Impact (Tutorial flyer)	14





Excerpt from

From the Center's Clearinghouse ...[*]

A Resource Aid:

Responding to Crisis at a School

This document is a hard copy version of a resource that can be downloaded at no cost from the Center's website (http://smhp.psych.ucla.edu)

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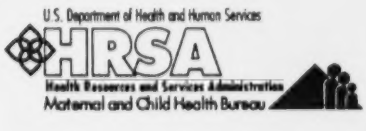
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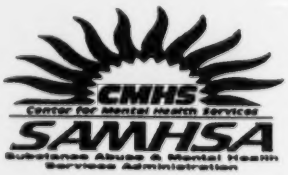


SCHOOL-BASED CRISIS INTERVENTION

Crises are dangerous opportunities.

Chinese saying

Crisis, emergency, disaster, catastrophe, tragedy, trauma -- all are words heard too frequently at schools today. Almost every school has had a major crisis; every school is likely to have one. Besides natural disasters such as earthquakes and fires, students experience violence and death related to the suicide of friends, gang activity, snipers, hostage-taking, and rape. Some students react with severe emotional responses -- fear, grief, post traumatic stress syndrome. Moreover, such experiences and other events that threaten their sense of worth and well-being can produce the type of intense personal turmoil that leads students to think about hurting themselves or others.

> If no effort is made to intervene, emotional reactions may interfere with a student's school and home performance, can be imminently life threatening, or may be the start of long-term psychosocial problems. And, when a significant portion of the student body is affected, major facets of a school's functioning are likely to be jeopardized.

As used here, the term, school-based crisis intervention, refers to a range of responses schools can plan and implement in response to crisis events and reactions. All school-based and school-linked staff can play an important role in crisis intervention.

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Who Should Be Responsible?

Given the complexity of crisis events and reactions, planning and implementing school-based crisis intervention require special expertise (e.g., how to deal with natural disasters as contrasted to dealing with gang violence or suicide, how to plan for crowd management, rumor control, aftermath counseling, prevention). Thus, individuals and subgroups with diverse expertise need to be involved, and all who are involved usually need additional specialized inservice training.

> Whatever happens at the school level is shaped by district policy and procedural guidelines. In most instances, the district's administration will have provided the school with detailed guidelines for handling major disasters during the emergency itself and in the immediate aftermath (see example in Section II). Such guidelines also should clarify available district support resources (e.g., district crisis teams, medical and counseling services).

It is rarer for districts to have addressed, in the same detail, policies and procedures for what to do in the days and weeks that follow the event and what to do to improve future responses or to prevent future occurrences where feasible.

> Regardless of what guidelines the district provides, it falls to the school to develop a specific operational plan and to identify and prepare personnel to carry it out. This might all be done by a school's administration. That is, they might assume the task of planning and then identifying and assigning specific duties to staff (e.g., school nurse, specific teachers, psychologist). However, as noted above, the diversity of expertise required suggests a broad-based approach to planning and implementation. Thus, schools probably will find the concept of a school-based crisis team useful.

The proper handling of school-wide crises is essential to minimizing negative impact on learning and mental health. A comprehensive crisis intervention approach provides ways for school personnel, students, and parents to return to normalcy as quickly as feasible, address residual (longer-term) psychosocial problems, and explore preventive measures for the future. To achieve these desirable outcomes, a school district must adopt, implement, and institutionalize a set of crisis intervention procedures.

> Developing procedures for a school-based response to crises requires mechanisms for initial planning, implementation, and ongoing evaluation and change. For purposes of this presentation, effective mechanisms to accomplish these tasks are seen as
> - a school-based planning committee (whose efforts hopefully are augmented by district support staff)
> - a school-based crisis team
>
> Note: The planning and crisis team may be one and the same or may be two separate and coordinated groups.

Rather than asking one person to take responsibility for organizing for crises, the school administration is advised to form a small planning committee of school staff. The individuals asked to serve, by role and interest, should be ready to evolve a working plan and become the nucleus of a school-based crisis team. They also should be given appropriate released or compensated time, support, recognition, and appreciation.

> In the best of circumstances, the district should provide not only policy and procedural guidelines, but support staff to help the school planning committee formulate a specific plan, organize and train the crisis team, and coordinate with relevant district and community resources.

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Planning for Crises

Every school needs a plan for school-based crisis intervention. It is important to anticipate the specifics of what may happen and how to react. Once the need for a plan is recognized, it underscores the need to identify *who* will be responsible for planning responses to crisis events.

Once identified, planners of school-based crisis intervention can work out criteria, procedures, and logistics regarding such general matters as

- who will assume what roles and functions in responding to a crisis
- what types of events the school defines as a crisis warranting a school-based response
- what defines a particular event as a crisis
- how will different facets of crisis response be handled (who, what, where)
- how to assess and triage medical and psychological trauma
- how to identify students and staff in need of aftermath intervention
- what types of responses will be made with respect to students, staff, parents, district, community, media
- what special provisions will be implemented to address language and cultural considerations
- which school personnel will make the responses
- how district and community resources will be used
- which personnel will review the adequacy of each response and make appropriate revisions in crises response plans
- what inservice staff development and training are needed.
- how will everyone be informed about emergency and crisis procedures

As part of the general plan, it is essential to address contingencies.
What will be done if someone is not at school to carry out their crisis response duties? What if a location is not accessible for carrying on a planned activity?

It should be stressed that school crises often are community crises. Therefore, the school's plan should be coordinated with community crisis response personnel and, where feasible, plans and resources should be seamlessly woven together. The same is true with respect to neighboring schools. A blending of planning and implementation resources assures a wider range of expertise and can increase cost-efficacy.

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Once a general plan is made, over time, planners can work out further details related to specific concerns (see Section VI of this resource aid). In doing so, they should give priority to those that seem to occur with the greatest frequency.

Figure 1 presents a matrix outlining the scope of crisis events and phases to be considered in intervention planning. In Section II, there is an outline of general ideas related to a school-based response to school-wide crises.

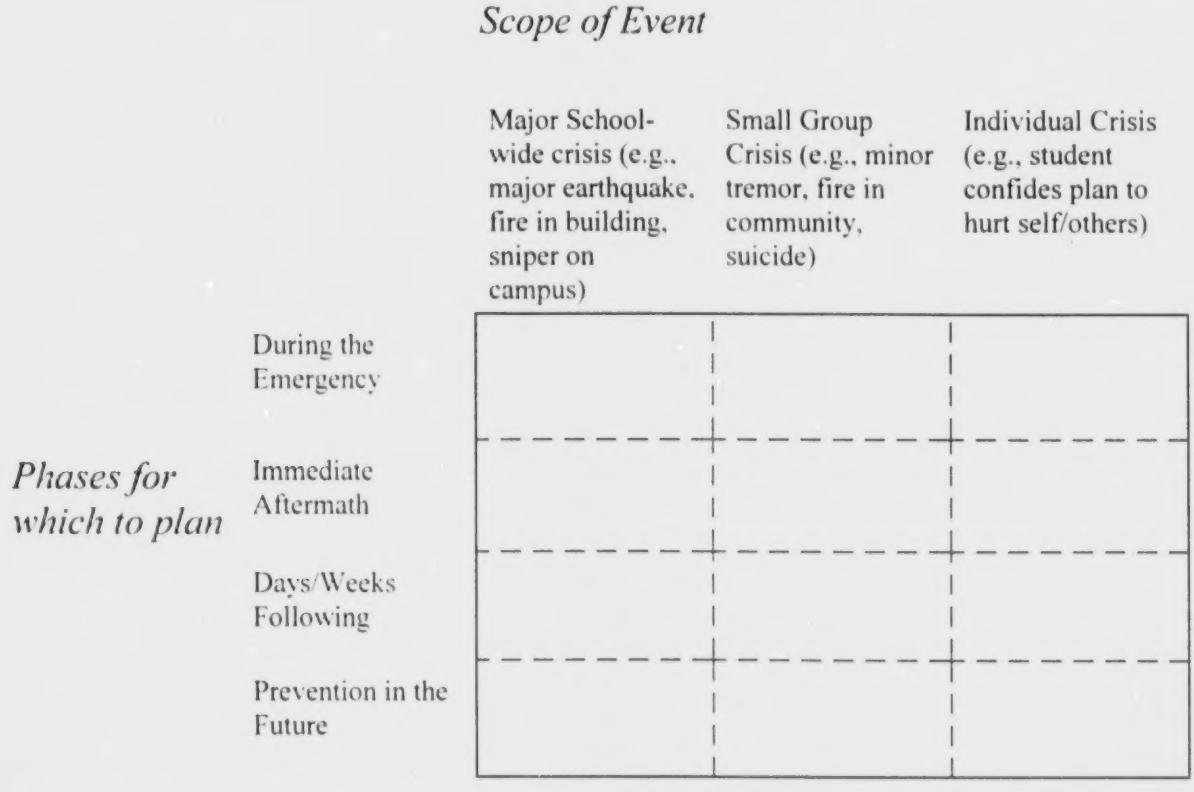

Scope of Event
Major School-wide crisis (e.g., major earthquake, fire in building, sniper on campus)
Small Group Crisis (e.g., minor tremor, fire in community, suicide)
Individual Crisis (e.g., student confides plan to hurt self/others)
Phases for which to plan
During the Emergency
Immediate Aftermath
Days/Weeks Following
Prevention in the Future

Figure 1. Scope of Crisis Events and Intervention Phases

Several points should be highlighted related to Figure 1. Clearly, the scope of the event (major school-wide crises as contrasted to small group or individual crises) profoundly shapes how many staff members are needed during the various phases of the crisis.

Also, difficulties that must be dealt with during the crisis itself raise many problems that are quite distinct from those arising in the immediate aftermath and in the days and weeks following the event (e.g., hysteria and fear as contrasted with grief reactions and post traumatic stress).

All newsletter articles are available online at http://smhp.psych.ucla.edu/news.htm

Addressing Barriers to Learning

New ways to think . . .
Better ways to link

Volume 4, Number 3
Summer, 1999

...consider the American penchant for ignoring the structural causes of problems. We prefer the simplicity and satisfaction of holding individuals responsible for whatever happens: crime, poverty, school failure, what have you. Thus, even when one high school crisis is followed by another, we concentrate on the particular people involved -- their values, their character, their personal failings -- rather than asking whether something about the system in which these students find themselves might also need to be addressed.

Alfie Kohn, 1999

Youth Suicide/ Depression/Violence

"I am sad all the time."
"I do everything wrong."
"Nothing is fun at all."
items from the
"Children's Depression Inventory"

Too many young people are not very happy. This is quite understandable among those living in economically impoverished neighborhoods where daily living and school conditions frequently are horrendous. But even youngsters with economic advantages too often report feeling alienated and lacking a sense of purpose.

Youngsters who are unhappy usually act on such feelings. Some do so in "internalizing" ways; some "act out;" and some respond in both ways at different times. The variations can make matters a bit confusing. Is the youngster just sad? Is s/he depressed? Is this a case of ADHD? Individualsmay display the same behavior and yet the causes may be different and vice versa. And, matters are further muddled by the reality that the causes vary.

The causes of negative feelings, thoughts, and behaviors range from environmental/system deficits to relatively minor group/individual vulnerabilities on to major biological disabilities (that affect only a small proportion of individuals). It is the full range of causes that account for the large number of children and adolescents who are reported as having psychosocial, mental health, or developmental problems. In the USA, estimates are approaching 20 percent (11 million).

Recent highly publicized events and related policy initiatives have focused renewed attention on youth suicide, depression, and violence. Unfortunately, such events and the initiatives that follow often narrow discussion of causes and how best to deal with problems.

Shootings on campus are indeed important reminders that schools must help address violence in the society. Such events, however, can draw attention away from the full nature and scope of violence done to and by young people. Similarly, renewed concern about youth suicide and depression are a welcome call to action. However, the actions must not simply reflect biological and psychopathological perspectives of cause and correction. The interventions must also involve schools and communities in approaches that counter the conditions that produce so much frustration, apathy, alienation, and hopelessness. This includes increasing the opportunities that can enhance the quality of youngsters' lives and their expectations for a positive future.

About Violence

Violence toward and by young people is a fact of life. And, it is not just about guns and killing. For schools, violent acts are multifaceted and usually constitute major barriers to student learning. As Curcio and First (1993) note:

> *Violence in schools is a complex issue. Students assault teachers, strangers harm children, students hurt each other, and any one of the parties may come to school already damaged and violated* [e.g., physically, sexually, emotionally, or negligently at home or on their way to or from school]. *The kind of violence an individual encounters varies also, ranging from mere bullying to rape or murder.*

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Clearly, the nature and scope of the problem goes well beyond the widely-reported incidents that capture media attention. We don't really have good data on how many youngsters are affected by all the forms of violence or how many are debilitated by such experiences. But few who have good reason to know would deny that the numbers are large. Far too many youngsters are caught up in cycles where they are the recipient, perpetrator, and sometimes both with respect to physical and sexual harassment ranging from excessive teasing and bullying to mayhem and major criminal acts. Surveys show that in some schools over 50% of the students have had personal property taken (including money stolen or extorted). Before recent campaigns for safe schools, one survey of 6th and 8th graders in a poor urban school found over 32% reporting they had carried a weapon to school -- often because they felt unsafe.

About Suicide and Depression

In the Surgeon General's *Call to Action to Prevent Suicide 1999*, the rate of suicide among those 10-14 years of age is reported as having increased by 100% from 1980-1996, with a 14% increase for those 15-19. (In this latter age group, suicide is reported as the fourth leading cause of death.) Among African-American males in the 15-19 year age group, the rate of increase was 105%. And, of course, these figures don't include all those deaths classified as homicides or accidents that were in fact suicides.

Why would so many young people end their lives? The search for answers inevitably takes us into the realm of psychopathology and especially the arena of depression. But we must not only go in that direction. As we become sensitive to symptoms of depression, it is essential to differentiate commonplace periods of unhappiness from the syndrome that indicates clinical depression. We must also remember that not all who commit suicide are clinically depressed and that most persons who are unhappy or even depressed do not commit suicide. As the National Mental Health Association cautions: "Clinical depression goes beyond sadness or having a bad day. It is a form of mental illness that affects the way one feels, thinks, and acts." And, it does so in profound and pervasive ways that can lead to school failure, substance abuse, and sometimes suicide.

Numbers for depression vary. The National Institute of Mental Health's figure is 1.5 million children and adolescents. The American Academy of Child and Adolescent Psychiatry estimates 3.0 million. Variability in estimates contributes to appropriate concerns about the scope of misdiagnoses and misprescriptions. Such concerns increase with reports that, in 1998, children 2-18 years of age received 1.9 million prescriptions for six of the new antidepressants (an increase of 96% over a 4 year period) and about a third of these were written by nonpsychiatrists -- generally pediatricians and family physicians. This last fact raises the likelihood that prescriptions often are provided without the type of psychological assessment generally viewed as necessary in making a differential diagnosis of clinical depression. Instead, there is overreliance on observation of such symptoms as: *persistent sadness and hopelessness, withdrawal from friends and previously enjoyed activities, increased irritability or agitation, missed school or poor school performance, changes in eating and sleeping habits, indecision, lack of concentration or forgetfulness, poor self-esteem, guilt, frequent somatic complaints, lack of enthusiasm, low energy, low motivation, substance abuse, recurring thoughts of death or suicide.*

Clearly, any of the above indicators is a reason for concern. However, even well trained professionals using the best available assessment procedures find it challenging to determine in any specific case (a) the severity of each symptom (e.g., when a bout of sadness should be labeled as profoundly persistent, when negative expectations about one's future should be designated as "hopelessness"), (b) which and how many symptoms are transient responses to situational stress, and (c) which and how many must be assessed as severe enough to warrant a diagnosis of depression.

Linked Problems

Wisely, the Surgeon General's report on suicide stresses the linkage among various problems experienced by young people. This point has been made frequently over the years, and just as often, its implications are ignored.

One link is life dissatisfaction. For any youngster and among any group of youngsters, such a state can result from multiple factors. Moreover, the impact on behavior and the degree to which it is debilitating will vary considerably. And, when large numbers are affected at a school or in a neighborhood, the problem can profoundly exacerbate itself. In such cases, the need is not just to help specific individuals but to develop approaches that can break the vicious cycle. To do so, requires an appreciation of the overlapping nature of the many "risk" factors researchers find are associated with youngsters' behavior, emotional, and learning problems.

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Risk Factors

Based on a review of over 30 years of research, Hawkins and Catalano (1992) identify the following 19 common risk factors that reliably predict youth delinquency, violence, substance abuse, teen pregnancy, and school dropout:

A. Community Factors
1. Availability of Drugs
2. Availability of Firearms
3. Community Laws and Norms Favorable Toward Drug Use, Firearms, and Crime
4. Media Portrayals of Violence
5. Transitions and Mobility
6. Low Neighborhood Attachment and Community Disorganization
7. Extreme Economic Deprivation

B. Family Factors
8. Family History of the Problem Behavior
9. Family Management Problems
10. Family Conflict
11. Favorable Parental Attitudes and Involvement in the Problem Behavior

C. School Factors
12. Early and Persistent Antisocial Behavior
13. Academic Failure Beginning in Late Elementary School
14. Lack of Commitment to School

D. Individual / Peer Factors
15. Alienation and Rebelliousness
16. Friends Who Engage in the Problem Behavior
17. Favorable Attitudes Toward the Problem Behavior
18. Early Initiation of the Problem Behavior

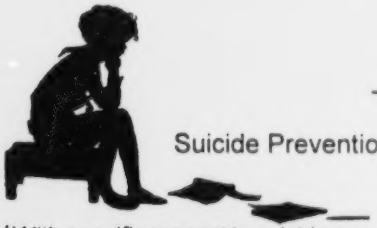
E. 19. Constitutional Factors

Hawkins, J.D. & Catalano, R.F. (1992). *Communities That Care; Action for Drug Abuse Prevention*. Jossey-Bass.

General Guidelines for Prevention

Various efforts have been made to outline guidelines for both primary and secondary (indicated) prevention. A general synthesis might include:

- Systemic changes designed to both minimize threats to and enhance feelings of competence, connectedness, and self-determination (e.g., emphasizing a caring and supportive climate in class and school-wide, personalizing instruction). Such changes seem easier to accomplish when s m a l l e r groupings of students are created by establishing smaller schools within larger ones and small cooperative groups in classrooms.
- Ensure a program is integrated into a comprehensive, multifaceted continuum of interventions.
- Build school, family, and community capacity for participation.
- Begin in the primary grades and maintain the whole continuum through high school.
- Adopt strategies to match the diversity of the consumers and interveners (e.g., age, socio economic status, ethnicity, gender, disabilities, motivation).
- Develop social, emotional, and cognitive assets and compensatory strategies for coping with deficit areas.
- Enhance efforts to clarify and communicate norms about appropriate and inappropriate behavior (e.g., clarity about rules, appropriate rule enforcement, positive "reinforcement" of appropriate behavior; campaigns against inappropriate behavior).



Suicide Prevention

With specific respect to suicide prevention programs, one synthesis from the U.S. Dept. of Health and Human Services delineates eight different strategies: (1) school gatekeeper training, (2) community gatekeeper training, (3) general suicide education, (4) screening, (5) peer support, (6) crisis centers and hotlines, (7) means restriction, and (8) intervention after a suicide (CDC, 1992). Analyses suggested the eight could be grouped into 2 sets -- those for enhancing identification and referral and those for directly addressing risk factors. And, recognizing the linkage among problems, the document notes:

Certainly potentially effective programs targeted to high-risk youth are not thought of as "youth suicide prevention" programs. Alcohol and drug abuse treatment programs and programs that provide help and services to runaways, pregnant teens, or school dropouts are examples of programs that address risk factors for suicide and yet are rarely considered to be suicide prevention programs.

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Enhancing Protective Factors and Building Assets

Those concerned with countering the tendency to overemphasize individual pathology and deficits are stressing resilience and preventive factors and developing approaches designed to foster such factors. The type of factors receiving attention is exemplified by the following list:

Community and School Protective Factors

- Clarity of norms/rules about behavior (e.g., drugs, violence)
- Social organization (linkages among community members/capacity to solve community problems/ attachment to community)
- Laws and consistency of enforcement of laws and rules about behavior (e.g., limiting ATOD, violent behavior)
- Low residential mobility
- Low exposure to violence in media
- Not living in poverty

Family and Peer Protective Factors

- Parental and/or sibling negative attitudes toward drug use
- Family management practices (e.g., frequent monitoring & supervision/consistent discipline practices)
- Attachment/bonding to family
- Attachment to prosocial others

Individual Protective Factors

- Social & emotional competency
- Resilient temperament
- Belief in societal rules
- Religiosity
- Negative attitudes toward delinquency
- Negative attitudes toward drug use
- Positive academic performance
- Attachment & commitment to school
- Negative expectations related to drug effects
- Perceived norms regarding drug use and violence

Note: This list is extrapolated from guidelines for submitting Safe, Disciplined, and Drug-Free Schools Programs for review by an Expert Panel appointed by the U.S. Department of Education (1999). The list contains only factors whose predictive association with actual substance use, violence, or conduct disorders have been established in at least one empirical study. Other factors are likely to be established over time.

The focus on protective factors and assets reflects the long-standing concern about how schools should play a greater role in promoting socio-emotional development and is part of a renewed and growing focus on youth development. After reviewing the best programs focused on preventing and correcting social and emotional problems, a consortium of professionals created the following synthesis of fundamental areas of competence (W.T. Grant Consortium on the School-Based Promotion of Social Competence , 1992):

Emotional

- identifying and labeling feelings
- expressing feelings
- assessing the intensity of feelings
- managing feelings
- delaying gratification
- controlling impulses
- reducing stress
- knowing the difference between feelings and actions

Cognitive

- self-talk -- conducting an "inner dialogue" as a way to cope with a topic or challenge or reinforce one's own behavior
- reading and interpreting social cues -- for example, recognizing social influences on behavior and seeing oneself in the perspective of the larger community
- using steps for problem-solving and decision-making -- for instance, controlling impulses, setting goals, identifying alternative actions, anticipating consequences
- understanding the perspectives of others
- understanding behavioral norms (what is and is not acceptable behavior)
- a positive attitude toward life
- self-awareness -- for example, developing realistic expectations about oneself

Behavioral

- nonverbal -- communicating through eye contact, facial expressiveness, tone of voice, gestures, etc.
- verbal -- making clear requests, responding effectively to criticism, resisting negative influences, listening to others, helping others, participating in positive peer groups

Note: With increasing interest in facilitating social and emotional development has come new opportunities for collaboration. A prominent example is the Collaborative for the Advancement of Social and Emotional Learning (CASEL) established by the Yale Child Study Center in 1994. CASEL's mission is to promote social and emotional learning as an integral part of education in schools around the world. Those interested in this work can contact Roger Weissberg, Executive Director, Dept. of Psychology, University of Illinois at Chicago, 1007 W. Harrison St., Chicago, IL 60607-7137. Ph. (312) 413-1008.

Source: UCLA Center for Mental Health in Schools, Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

What Makes Youth Development Programs Effective?

From broad youth development perspective, the American Youth Policy Forum (e.g, 1999) has generated a synthesis of "basic principles" for what works. Based on analyses of evaluated programs, they offer the following 9 principles:

- *implementation quality*
- *caring, knowledgeable adults*
- *high standards and expectations*
- *parent/guardian participation*
- *importance of community*
- *holistic approach*
- *youth as resources/community service and service learning*
- *work-based learning*
- *long-term services/support and follow-up*

See *More Things That Do Make a Difference for Youth* (1999). Available from American Youth Policy Forum. Ph: 202/775-9731.

Initiatives focusing on resilience, protective factors, building assets, socio-emotional development, and youth development all are essential counter forces to tendencies to reduce the field of mental health to one that addresses only mental illness.

System Change

When it is evident that factors in the environment are major contributors to problems, such factors must be a primary focal point for intervention. Many aspects of schools and schooling have been so-identified. Therefore, sound approaches to youth suicide, depression, and violence must encompass extensive efforts aimed at systemic change. Of particular concern are changes that can enhance a caring and supportive climate and reduce unnecessary stress throughout a school. Such changes not only can have positive impact on current problems, they can prevent subsequent ones.

Caring has moral, social, and personal facets. From a psychological perspective, a classroom and school-wide atmosphere that encourages mutual support and caring and creates a sense of community is fundamental to preventing learning, behavior, emotional, and health problems. Learning and teaching are experienced most positively when the learner *cares* about learning, the teacher *cares* about teaching, and schools function better when all involved parties *care* about each other. This is a key reason why caring should be a major focus of what is taught and learned.

Caring begins when students first arrive at a school. Schools do their job better when students feel truly welcome and have a range of social supports. A key facet of welcoming is to connect new students with peers and adults who will provide social support and advocacy. Over time, caring is best maintained through personalized instruction, regular student conferences, activity fostering social and emotional development, and opportunities for students to attain positive status. Efforts to create a caring classroom climate benefit from programs for cooperative learning, peer tutoring, mentoring, advocacy, peer counseling and mediation, human relations, and conflict resolution. Clearly, a myriad of strategies can contribute to students feeling positively connected to the classroom and school.

Given the need schools have for home involvement, a caring atmosphere must also be created for family members. Increased home involvement is more likely if families feel welcome and have access to social support at school. Thus, teachers and other school staff need to establish a program that effectively welcomes and connects families with school staff and other families in ways that generate ongoing social support.

And, of course, school staff need to feel truly welcome and socially supported. Rather than leaving this to chance, a caring school develops and institutionalizes a program to welcome and connect new staff with those with whom they will be working.

What is a psychological sense of com munity?

People can be together without feeling connected or feeling they belong or feeling responsible for a collective vision or mission. At school and in class, a psychological sense of community exists when a critical mass of stakeholders are committed to each other *and* to the setting's goals and values *and* exert effort toward the goals and maintaining relationships with each other.

A perception of community is shaped by daily experiences and probably is best engendered when a person feels welcomed, supported, nurtured, respected, liked, connected in reciprocal relationships with others, and a valued member who is contributing to the collective identity, destiny, and vision. Practically speaking, such feelings seem to arise when a critical mass of participants not only are committed to a collective vision, but also are committed to being and working together in supportive and efficacious ways. That is, a conscientious effort by enough stakeholders associated with a school or class seems necessary for a sense of community to develop and be maintained. Such an effort must ensure effective mechanisms are in place to provide support, promote self-efficacy, and foster positive working relationships.

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

There is an clear relationship between maintaining a sense of community and countering alienation and violence at school. Conversely, as Alfie Kohn cautions:

> The more that ... schools are transformed into test-prep centers -- fact factories, if you will -- the more alienated we can expect students to become.

Knowing What to Look For & What to Do

Of course, school staff must also be prepared to spot and respond to specific students who manifest worrisome behavior. Recently, the federal government circulated a list of "Early Warning Signs" that can signal a troubled child. Our Center also has put together some resources that help clarify what to look for and what to do. A sampling of aids from various sources is provided at the end of this article. In addition, see *Ideas into Practice* on following page.

Concluding Comments

In current practice, schools are aware that violence must be addressed with school-wide intervention strategies. Unfortunately, prevailing approaches are extremely limited, often cosmetic, and mostly ineffective in dealing with the real risk factors.

In addressing suicide, depression, and general life dissatisfaction, practices tend to overemphasize individual and small group interventions. Given the small number of "support" service personnel at a school and in poor communities, this means helping only a small proportion of those in need.

If schools are to do a better job in addressing problems ranging from interpersonal violence to suicide, they must adopt a model that encompasses a full continuum of interventions -- ranging from primary prevention through early-after-onset interventions to treatment of individuals with severe and pervasive problems. School policy makers must quickly move to embrace comprehensive, multi-faceted school-wide and community-wide models for dealing with factors that interfere with learning and teaching. Moreover, they must do so in a way that fully integrates the activity into school reform at every school site.

Then, schools must restructure how they use existing education support personnel and resources to ensure new models are carried out effectively. This restructuring will require *more than* outreach to link with community resources (and certainly *more than* adopting school-linked services), *more than* coordinating school-owned services with each other and with community services, and *more than* creating Family Resource Centers, Full Service Schools, and Community Schools.

Restructuring to develop truly comprehensive approaches requires a basic policy shift that moves schools from the inadequate two component model that dominates school reform to a three component framework that guides the weaving together of school and community resources to address barriers to development and learning. Such an expanded model of school reform is important not only for reducing suicide, depression, and violence among all children and adolescents, it is essential if schools are to achieve their stated goal of ensuring all students succeed.

Cited References and A Few Resource Aids

Curcio, J. & First, P. (1993). *Violence in the Schools: How to proactively prevent and defuse it.* Newbury Park, CA: Corwin Press.

Kohn, A. (Sept. 1999). Constant frustration and occasional violence: The legacy of American high schools. *American School Board Journal.* On the web at: http://www.asbj.com/current/coverstory/html

The Surgeon General's Call to Action to Prevent Suicide 1999. Available from the U.S. Dept. of Health & Human Services. Download-- http://www.mentalhealth.org/links/suicide.htm

Early Warning, Timely Response: A Guide to Safe Schools (1999). Printed version available from ED PUBS toll-free at 1-877-4ED-PUBS (1-877-433-7827) or by e-mail at edpuborders@aspensys.com. Can be downloaded from web. http://www.ed.gov/offices/OSERS/OSEP/earlywrn.html

Youth Suicide Prevention Programs: A Resource Guide (1992). Available from the U.S. Dept. of Health & Human Services, CDC. Can be downloaded from http://aepo-xdv-www.epo.cdc.gov/wonder/prevguid/p0000024/p0000024.htm

The following are resources put together at our Center. All are available as described on p. 3 (*Center News*); most can be downloaded through our website: *http://smhp.psych.ucla.edu/*.

- >*Screening/Assessing Students: Indicators and Tools*
- >*Responding to Crisis at a School*
- >*Violence Prevention and Safe Schools*
- >*Social and Interpersonal Problems Related to School Aged Youth*
- >*Affect and Mood Problems Related to School Aged Youth*
- >*Conduct and Behavior Problems in School Aged Youth*
- >*What Schools Can Do to Welcome and Meet the Needs of All Students and Families*
- >*Protective Factors (Resiliency)*

Some Websites:

Safe and Drug Free Schools Office, U.S. Dept. of Educ. http://www.ed.gov/offices/OESE/SDFS
National Institute of Mental Health: http://www.nimh.nih.gov
National School Safety Center: http://nssc1.org
Youth Suicide Prevention Program: http://depts.washington.edu/ysp
Suicide Resources on the Internet: http://psychcentral.com/helpme.htm

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Ideas into Practice
When a Student Seems Dangerous to Self or Others

What should you do if you come upon a youngster who seems about to commit a violent act against self or others? The following points are extrapolated from guidelines usually suggested for responding when a student talks of suicide. First, you must assess the situation and reduce the crisis state.

Then, here's some specific suggestions for

When a Student Talks of Suicide . . .

What to do:

- Send someone for help; you'll need back-up.
- Remain calm; remember the student is overwhelmed and confused as well as ambivalent.
- Get vital statistics, including student's name, address, home phone number and parent's work number.
- Encourage the student to talk. Listen! Listen! Listen! And when you respond, reflect back what you hear the student saying. Clarify, and help him/her define the problem, if you can.

Consider that the student is planning suicide. How does the student plan to do it, and how long has s/he been planning and thinking about it? What events motivated the student to take this step?

- Clarify some immediate options (e.g., school and/or community people who can help).
- If feasible, get an agreement to no-suicide ("No matter what, I will not kill myself.")
- Involve parents for decision making and follow-through and provide for ongoing support and management of care (including checking regularly with parents and teachers).

What to avoid:

- Don't leave the student alone and don't send the student away
- Don't minimize the student's concerns or make light of the threat
- Don't worry about silences; both you and the student need time to think
- Don't fall into the trap of thinking that all the student needs is reassurance
- Don't lose patience
- Don't promise confidentiality -- promise help and privacy
- Don't argue whether suicide is right or wrong

When a Student Attempts Suicide . . .

A student may make statements about suicide (in writing assignments, drawing, or indirect verbal expression). Another may make an actual attempt using any of a variety of means. In such situations, you must act promptly and decisively.

What to do:

- Be directive. Tell the student, "Don't do that; stand there and talk with me." "Put that down." "Hand me that." "I'm listening."
- Mobilize someone to inform an administrator and call 911; get others to help; you'll need back-up.
- Clear the scene of those who are not needed.
- An "administrator" should contact parents to advise them of the situation and that someone will call back immediately to direct the parent where to meet the youngster.
- Look at the student directly. Speak in a calm, low voice tone. Buy time. Get the student to talk. Listen. Acknowledge his or her feelings "You are really angry." "You must be feeling really hurt."
- Secure any weapon or pills; record the time any drugs were taken to provide this information to the emergency medical staff or police.
- Get the student's name, address and phone.
- Stay with the pupil; provide comfort.
- As soon as feasible, secure any suicide note, record when the incident occurred, what the pupil said and did, etc.
- Ask for a debriefing session as part of taking care of yourself after the event.

What to avoid:

- Don't moralize ("You're young, you have everything to live for.")
- Don't leave the student alone (even if the student has to go to the bathroom).
- Don't move the student.

In all cases, show concern and ask questions in a straightforward and calm manner. Show you are willing to discuss suicide and that you aren't appalled or disgusted by it. Open lines of communication. Get care for the student.

A Few References

Compas, B.E., Connor, J., & Wadsworth, M. (1997). Prevention of depression. In R.P. Weissberg, T. Gullota, et al., (Eds.), *Healthy children 2010: Enhancing children's wellness.* Thousand Oaks, CA: Sage

Fairchild, T., et al. (Eds.) (1997). *Crisis intervention strategies for school-based helpers* (2nd ed.) Springfield, IL: Charles Thomas Pub.

Seligman, M.E.P. (1995). *The optimistic child.* New York: Harper Perennial.

Weiner, M. (1989). Psychopathology reconsidered: Depression interpreted as psychosocial transactions. *Clinical Psych-ology Review, 9,* 295-321.

Source: UCLA Center for Mental Health in Schools: Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Flyer

Reducing Crisis and Minimizing Their Impact on Learning

What is the role of the school in responding to crises?

Can our response help students return to learning more quickly?

Can we anticipate and prevent some crises?

Want to learn more?

See the brief articles that have been posted_____.

Join a tutorial on:

Crisis Responses and Prevention

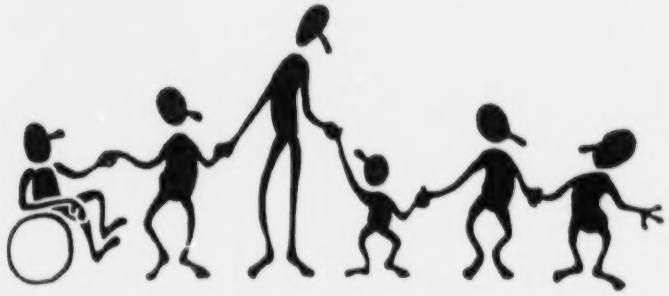
Time:

Place:

Topic 1: Reducing the impact on crises through preparedness.

Reading & Activity

		Page
Reading.	From: *Responding to a Crisis at a School, "Some Key Considerations in Establishing a System for School-Based Crisis Response"* *(pp. 17-27 in original document)*	16
Activity.	Use the various attached materials as stimuli and tools to focus application of what has been read	
	(1) *Outline What Has Been Learned so Far* - Develop a brief outline of what you have learned about how schools can reduce the impact of crises by preparing to respond. (use the attached work sheet)	28
	(2) *Discussion Session Exploring What Has Been Outlined* – Form an informal discussion and/or a formal study group (see the attached guide.)	29
	(3) *Outline revision* – Make ongoing revisions in the outline (use the attached guide)	30
	(4) *Review the self study survey entitled:* Crisis Assistance and Prevention (attached)	31



Excerpt from

From the Center's Clearinghouse ...[*]

A Resource Aid:

Responding to Crisis at a School

This document is a hard copy version of a resource that can be downloaded at no cost from the Center's website (http://smhp.psych.ucla.edu).

*The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA.
Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095- 1563
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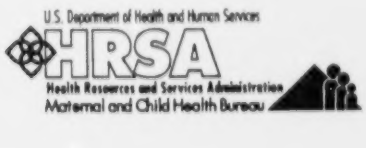
Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.


U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

Some Key Considerations in Establishing a System for School-Based Crisis Response

The following nine points provide answers to some basic concerns that arise during discussions of school-based crisis response.

(1) Scope of events

All schools require a clear set of emergency procedures for dealing with major, school-wide crises (e.g., earthquake, fire, snipers) when they occur and in the immediate aftermath.

Decisions have to be made about whether the scope of crisis response will include specified procedures for any of the following:

- crises that affect smaller segments of the student body
- crises experienced by individual students (e.g., drug overdose, suicide attempt)
- community events that produce strong reactions among students at school (e.g., earthquakes that occur during nonschool hours, a neighborhood shooting of a gang member who is student)
- planning responses (e.g., psychological support) for helping (treating/referring) traumatized students (staff?) in the days and weeks following an event
- preventive procedures

(2) Crisis criteria

When should an event be seen as requiring a crisis response?

With the exception of most major, school wide crises, crises tend to be in the eye of the beholder. Thus, some school personnel are quite liberal and others are quite conservative in labeling events as crises.

After deciding on the scope of events to be treated as crisis, the dilemma of the planners and ultimately of the decision makers is that of establishing a set of checks and balances to ensure potential crises are not ignored *and* that there is not an overreaction to events that should not be treated as crises. Given the inevitability of differences regarding how an event is perceived, efforts to formulate crisis criteria probably should focus on delineating an expedient *process* for deciding rather than the more difficult task of detailing what is and isn't a crisis.

For example, one school developed a process whereby each member of its crisis team was encouraged to take the initiative of contacting another team member whenever s/he felt an event might warrant a crisis response. If the contacted team member agreed that the event should be seen as a crisis, the rest of the crisis team were contacted immediately for a quick meeting and vote. If the majority concurred, the event was defined as a crisis and appropriate crisis responses were implemented.

(3) Who needs aftermath help?

Again, there will be inevitable differences in perception. It is clear, however, that plans must be in place to provide help and/or referral whenever staff, parents, or students themselves indicate that a student is experiencing significant emotional reactions to a crisis. Usually, all that is needed is a procedure for alerting everyone to the possibility of emotional reactions and who on the staff will be providing support and counseling and/or referrals.

Planners also may want to consider what types of general responses may be appropriate with regard to specific types of events. Should there be a "debriefing" meeting for the entire school? for specific subgroups?

And decisions will have to be made about whether there will be support/counseling/referrals for emotional reactions of school staff.

(4) Types of responses

Planning focuses on delineating, establishing, and maintaining procedures and equipment and assigning responsibilities for (1) communication, (2) direction and coordination, and (3) health and safety during each of the four phases specified in the accompanying Figure. It encompasses every major detail related to who, what, where, when, and how.

Other handouts in this section provide examples of the types of activities to be considered in such planning.

A special need arises with respect to handling the media. It has become increasingly evident that each school should identify and train a specific person to act as a spokesperson in order to minimize the ways media reports can exacerbate difficult situations.

(5) Providing for Language and Cultural Differences

The influx of immigrants has increased the necessity of identifying individuals who speak the language and are aware of relevant cultural considerations that may arise during a crisis response. If one is fortunate enough to have such individuals on the school staff (in professional or nonprofessional positions), then planning involves delineating their roles during the crisis, clarifying how they can be freed from other responsibilities, and how they can be trained to carry out their special roles. If such persons are not readily available, then planning also must address how to recruit such help. Possible sources include mature students, parents, staff from nearby community agencies, other community volunteers.

For **Scope of Crisis Events and Intervention Phases** see Figure 1, page 8.

(6) Which School Staff Respond to Crises

Obviously, there are some staff who because of their role are critical to the success of crisis response (e.g., school nurses, psychologists, specific administrators, office staff, plant manager). In addition, there are others who have relevant interests and special abilities (e.g., first aid and counseling skills). To provide a comprehensive and coordinated response, plans should focus on ways to establish, train, and maintain a Crisis Intervention Team consisting of a combination of both types of staff (i.e., role-relevant and interested individuals). In all likelihood, there will be considerable overlap between the Crisis Planning Committee and the Crisis Intervention Team. Plans also must be made to identify, train, and maintain a number of individuals who will play supplementary roles when there are major disasters such as fires, earthquakes, and large-scale violence on campus (e.g., all school personnel, designated students, parent liaisons).

(7) Other District and Community Resources

Some crises require mobilization of off-campus resources. Planning involves identifying available resources and clarifying steps by which they will be mobilized when needed.

(8) Crisis Debriefing

At an appropriate time after a crisis response, an analysis of the quality of the response should be made to identify the need for improved procedures and additional training. For this to occur, a planning committee must designate who will organize the debriefing and who will be responsible for following through with developing improved procedures and organizing training sessions.

(9) Inservice Training

In addition to training needs that emerge from debriefing analyses, plans should be made for ongoing staff development based on requests from staff involved in crisis planning and intervention.

Major Facets of Crises Response

During the emergency

- communication (e.g., sounding the alarm if necessary; clarifying additional steps and providing information about the event, location of first aid stations if needed, etc.; rumor control; dealing with the media; keeping track of students and staff; responding to parents; interfacing with rest of the district and community)
- direction and coordination (e.g., running an emergency operations center; monitoring problems; problem solving)
- health and safety (e.g., mitigating hazards to protect students and staff; providing them with medical and psychological first aid; providing for search and rescue, security, evacuation)

Immediate aftermath

- communication (e.g., clarifying causes and impact and debunking rumors; providing information about available resources for medical and psychological help)
- direction and coordination (e.g., determining need to maintain emergency operations center; continuing to monitor problems and problem solve)
- health and safety (e.g., continuing with activities initiated during the event)

Days/weeks following

- communication (e.g., providing closure to students, staff, parents, district, community)
- direction and coordination (e.g., continuing to monitor problems and problem solve)
- health and safety (e.g., providing for those in need of longer-term treatment either through provision of direct services or referral; case management)

Prevention

- communication (e.g., holding debriefing meetings to clarify deficiencies in response to the crisis)
- direction and coordination (e.g., using debriefing analyses to plan ways to prevent, if feasible, similar events from occurring, to minimize the impact of unavoidable events, to improve crisis response procedures, to enhance resources)
- health and safety (e.g., providing education for students, staff, parents)

Responding to Crises: A Few General Principles

Immediate Response **-- Focused on Restoring Equilibrium**

In responding:

- Be calm, direct, informative, authoritative, nurturing, and problem-solving oriented.
- Counter denial, by encouraging students to deal with facts of the event; give accurate information and explanations of what happened and what to expect -- never give unrealistic or false assurances.
- Talk with students about their emotional reactions and encourage them to deal with such reactions as another facet of countering denial and other defenses that interfere with restoring equilibrium.
- Convey a sense hope and positive expectation -- that while crises change things, there are ways to deal with the impact.

Move the Student from Victim to Actor

- Plan with the student promising, realistic, and appropriate actions they will pursue when they leave you.
- Build on coping strategies the student has displayed.
- If feasible, involve the student in assisting with efforts to restore equilibrium.

Connect the Student with Immediate Social Support

- Peer buddies, other staff, family -- to provide immediate support, guidance, and other forms of immediate assistance.

Take Care of the Caretakers

- Be certain that support systems are in place for staff in general
- Be certain that support (debriefing) systems are in place for all crisis response personnel.

Provide for Aftermath Interventions

- Be certain that individuals needing follow-up assistance receive it.

Crisis Response Checklist

In the midst of a crisis, it is hard to remember all the specific steps and preparatory plans that have been discussed. Each site and each person responsible for crisis response needs to have a checklist that provides a ready and visible reference guide for use during a crisis. Such a checklist is also an important training tool. The following is an outline of what such a checklist might cover.

I. Immediate Response

Check to be certain that

____ appropriate "alarms' have been sounded

____ all persons with a crisis role are mobilized and informed as to who is coordinating the response and where the coordination/emergency operation center and medical and psychological first aid centers are located

This may include coordinators for

____ overall crisis response
____ first aid (medical, psychological)
____ media
____ communications
____ crowd management
____ transportation

____ phone trees are activated

____ team leader and others clarify whether additional resources should be called in (from the District or community -- such as additional medical and psychological assistance, police, fire)

____ all assignments are being carried out (including provisions for classroom coverage for crisis response team members and for any instances of a staff death)

____ corrective steps are being taken when the response is inadequate

____ all communication needs are addressed by implementing planned means for information sharing and rumor control (e.g. Public Address announcements, circulation of written statements, presentations to staff/students/ parents in classes or in special assemblies);

This includes communications with

____ staff
____ students
____ crisis team
____ media
____ home
____ district offices and other schools
____ community
____ fire, police

____ plans for locating individuals are implemented (e.g., message center, sign-in and sign-out lists for staff and students)

____ specific intervention and referral activity are implemented (e.g., triage, first-aid, search, rescue, security, evacuation, counseling, distribution of information about resources and referral processes -- including teentalk and suicide prevention lines and interviews to assess need for individual counseling)

____ support and time out breaks for crisis workers are implemented

____ informal debriefings of crisis workers are done to assess how things are going and what will be required in the way of follow-up activity.

II. Follow-up Activity

In the **aftermath**, check to be certain that

____ continuing communication needs are addressed (clarifying causes and impact; debunking rumors, updating facts, providing closure; updating information on available resources)

____ if relevant, family contacts are made to learn funeral and memorial service arrangements, and to determine if there is additional assistance the school can provide (School-related memorial services for gang members, suicides, etc. are controversial; clear policies should be established in discussing crisis response plans.)

____ crisis-related problems continue to be monitored and dealt with (including case management of referrals and extended treatment)

____ facets of crisis response that are no longer needed are brought to an appropriate conclusion

____ debriefing meetings are held (to appreciate all who helped, clarify deficiencies in crisis response, and make revisions for the next time)

____ crisis response plans are revised and resources enhanced for dealing with the next crisis

____ additional training is planned and implemented

____ appropriate prevention planning is incorporated (e.g., at least to minimize the impact of such events)

Example of One District's *Crisis Checklist*

I. ASSESSMENT

___A. Identify problem and determine degree of impact on school.

___B. Take steps to secure the safety and security of the site as needed.
(see Emergency Disasters Procedures Manual, Sept. 1994)

___C. Make incident report to district administrator.

___D. Determine if additional support is needed.
___1. Call school police and/or city police
___2. Call Cluster Crisis Team
___3. Call other district crisis personnel

___E. Alter daily/weekly schedule as needed.

II. INTERVENTION: COMMUNICATION

___A. Set up a Command Center

___B. Establish Sign-In Procedures at ALL campus entry sites*

___C. Administrator/designee/crisis manager should:
___1. Review facts/determine what information should be shared
___2. Consider police investigation parameters
___3. Notify family with sensitivity and dispatch. (Consider a personal contact with family.)

___D. Develop and disseminate bilingual FACT SHEET (written bulletin)
___1. Faculty
___2. Students
___3. Parents/Community

___E. Begin media interactions.
___1. Identify a media spokesperson (Office of Communications may be utilized)
___2. Designate a location for media representatives.*

___F. Contact neighboring schools

___G. Contact schools of affected students siblings.

___H. Other communication activities
___1. Classroom presentations/discussions
___2. Parent/community meetings
___3. School staff meeting

___I. Provide for RUMOR CONTROL
___1. Keep a TV set or radio tuned to a news station
___2. Verify ALL facts heard
___3. Update Fact Sheet as needed
___4. Utilize student leaders:
a) As sources knowledgeable of rumors among students
b) As peer leaders to convey factual information
c) As runners (written bulletins should be sealed when necessary)

III. INTERVENTION: FIRST AID AND EMERGENCY RELEASE PLAN

___A. Initiate First Aid Team procedures

___B. Designate Emergency Health Office location*

___C. Initiate Emergency Release Plan procedures

___D. Designate student check-out location*

IV. INTERVENTION: PSYCHOLOGICAL FIRST AID/COUNSELING

___A. Logistics: Designate rooms/locations/areas**
- ___1. Individual counseling -- Location: _____ **
- ___2. Group counseling -- Location: _____ **
- ___3. Parents -- Location: _____ **
- ___4. Staff (certificated and classified) -- Location: _____ **
- ___5. Sign-In for Support Services -- Location: _____

___B. Initiate the referral process, including procedures for self-referral.
- ___1. Identify a crisis team member to staff all locations.**
- ___2. Provide bilingual services as needed.
- ___3. Distribute appropriate forms for student counseling referrals to staff.
- ___4. Disseminate student referral information to teachers and other staff.

___C. Identify and contact high risk students.

___D. Identify and contact other affected students, staff, and personnel.

___E. Initiate appropriate interventions:
- Individual counseling
- Group counseling
- Parent/community meetings
- Staff meetings (ALL staff)
- Classroom activities, presentations
- Referrals to community agencies

IV. INTERVENTION: DISSEMINATE APPROPRIATE HANDOUTS TO STAFF/PARENTS

V. INTERVENTION: DEBRIEFING

___A. Daily and mandatory

___B. Crisis intervention activities
___1. Review the actions of the day
___2. Identify weaknesses and strengths of crisis interventions
___3. Review status of referred students
___4. Prioritize needs/personnel needed the next day
___5. Plan follow-up actions

___C. Allow time for emotional debriefing

* Logistics/room designations/space allocations
** Support personnel needed for these locations

Developed by the Los Angeles Unified School District

Excerpted From The National Institute of Mental Health.....

Helping Children Cope With Violence and Disasters

The National Institute of Mental Health has joined with other Federal agencies to address the issue of reducing school violence and assisting children who have been victims of or witnesses to violent events. Recent nationally reported school shootings such as those that occurred in Bethel, Alaska; Pearl, Mississippi; West Paducah, Kentucky; Jonesboro, Arkansas; Edinboro, Pennsylvania; Springfield,Oregon; and Littleton, Colorado have shocked the country. Many questions are being asked about how these tragedies could have been prevented, how those directly involved can be helped, and how we can avoid such events in the future.

Research has shown that both adults and children who experience catastrophic events show a wide range of reactions. Some suffer only worries and bad memories that fade with emotional support and the passage of time. Others are more deeply affected and experience long-term problems. Research on post-traumatic stress disorder (PTSD) shows that some soldiers, survivors of criminal victimization, torture and other violence, and survivors of natural and man-made catastrophes suffer long-term effects from their experiences. Children who have witnessed violence in their families, schools, or communities are also vulnerable to serious long-term problems. Their emotional reactions, including fear, depression, withdrawal or anger, can occur immediately or some time after the tragic event. Youngsters who have experienced a catastrophic event often need support from parents and teachers to avoid long-term emotional harm. Most will recover in a short time, but the minority who develop PTSD or other persistent problems need treatment.

The school shootings caught the Nations attention, but these events are only a small fraction of the many tragic episodes that affect children's lives. Each year many children and adolescents sustain injuries from violence, lose friends or family members, or are adversely affected by witnessing a violent or catastrophic event. Each situation is unique, whether it centers upon a plane crash where many people are killed, automobile accidents involving friends or family members, or natural disasters such as Hurricane Andrew where deaths occur and homes are lost-but these events have similarities as well, and cause similar reactions in children. Helping young people avoid or overcome emotional problems in the wake of violence or disaster is one of the most important challenges a parent, teacher, or mental health professional can face. The purpose of this fact sheet is to tell what is known about the impact of violence and disasters on children and suggest steps to minimize long-term emotional harm.

For more information visit http://www.nimh.gov/publicat/violence.cfm

NIMH, 2000.

Excerpted from FEMA For Kids : Resources for Parents & Teachers
For more information visit: http://www.fema.gov/kids/tch_after.htm

After a Disaster: How to Help Child Victims

Children who experience an initial traumatic event before they are 11 years old are three times more likely to develop psychological symptoms than those who experience their first trauma as a teenager or later. But children are able to cope better with a traumatic event if parents, friends, family, teachers and other adults support and help them with their experiences. Help should start as soon as possible after the event.

It's important to remember that some children may never show distress because they don't feel upset, while others may not give evidence of being upset for several weeks or even months. Other children may not show a change in behavior, but may still need your help.

Children may exhibit these behaviors after a disaster:

- Be upset over the loss of a favorite toy, blanket, teddy bear or other times that adults might consider insignificant, but which are unimportant to the child.
- Change from being quiet, obedient and caring to loud, noisy and aggressive or may change from being outgoing to shy and afraid.
- Develop nighttime fears. They may be afraid to sleep alone at night, with the light off, to sleep in their own room, or have nightmares or bad dreams.
- Be afraid the event will reoccur.
- Become easily upset, crying and whining.
- Lose trust in adults. After all, their adults' were not able to control the disaster
- Revert to younger behavior such as bed wetting and thumb sucking.
- Not want parents out of their sight and refuse to go to school or childcare.
- Feel guilty that they caused the disaster because of something they had said or done.
- Become afraid of wind, rain, or sudden loud noises
- Have symptoms of illness, such as headaches, vomiting or fever.
- Worry about where they and their family will live.

Worksheet

Outline What Has Been Learned so Far

Use this worksheet to develop a brief outline of what you have learned about how schools can reduce the impact of crises by preparing to respond.

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Discussion Session to Explore the Outlined Features

One of the best ways to explore what you are learning is to discuss it with others. Although this can be done informally with friends and colleagues, a regular study group can be a wonderful learning experience – if it is properly designed and facilitated.

Below are a few guidelines for study groups involved in pursuing a Training Tutorial.

(1) Put up a notice about the Training Tutorial, along with a sign up list for those who might be interested participating in a study group as they pursue the tutorial. On the sign-up list, offer several times for a meeting to organize the group.

(2) Inform interested parties about the where and when of the meeting to organize the group.

(3) Group decides on the following:

  (a) meeting time, place, number and length of sessions, amenities, etc.

  (b) how to handle session facilitation (e.g., starting and stopping on time, keeping the group task-focused and productive)

(4) All group members should commit to keeping the discussion focused as designated by the tutorial content and related activities. If the discussion stimulates other content, set up a separate opportunity to explore these matters.

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Revise your Outline

After any discussion and as other aspects of the tutorial are explored, it is important to revisit the outline of what you have learned about how school can outreach to enhance crisis response and prevention and to make additions.

Because of the fundamental nature of the topic, we recommend creating a personal journal in which new ideas and insights are regularly recorded related to various key facets of the school's efforts to address barriers to learning and teaching. One section of the journal should focus on crisis response and prevention. A periodic review of the journal will provide an ongoing process for considering revision in the ever-developing outline that reflects your ongoing learning on a given topic.

Also, if feasible, it is useful to pull together the study group periodically to discuss any major changes in thinking.

Source: UCLA Center for Mental Health in Schools: Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

Review the Self-Study Survey entitled:

Crisis Assistance and Prevention

Attached is a self-study survey. For purposes of this tutorial, just read over the items. These provide a sense of what might take place at a school with respect to responding to and preventing crises.

The survey itself can be used at a school in a number of ways (see the introductory page entitled: "About the Self-Study Process to Enhance the Component for Addressing Barriers to Student Learning").

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

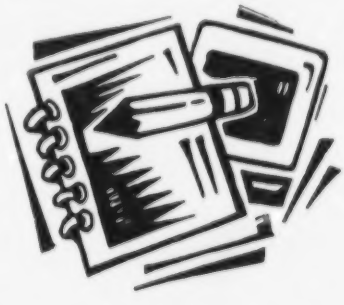
Mental Health in Schools Center Training and Technical Assistance

Excerpt From:

From the Center's Clearinghouse . . . *

A Resource Aid Packet on

Addressing Barriers to Learning: A Set of Surveys to Map What a School Has and What it Needs



This document is a hardcopy version of a resource that can be downloaded at no cost from the Center's website (http://www.smhp.psych.ucla.edu).

The Center is co-directed by Howard Adelman and Linda Taylor and operates under the auspices of the School Mental Health Project, Dept. of Psychology, UCLA.
Address: Center for Mental Health in Schools, Box 951563, Los Angeles, CA 90095-1563
Phone: (310) 825-3634 | Fax: (310) 206-8716 | E-mail: smhp@ucla.edu | Website: http://smhp.psych.ucla.edu

Support comes in part from the Office of Adolescent Health, Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration (Project #U93 MC 00175) with co-funding from the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Both are agencies of the U.S. Department of Health and Human Services.

U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

CMHS
Center for Mental Health Services
SAMHSA
Substance Abuse & Mental Health Services Administration

Surveying and Planning to Enhance Efforts to Address Barriers to Learning at a School Site

The following resource aides were designed as a set of self-study surveys to aid school staff as they try to map and analyze their current programs, services, and systems with a view to developing a comprehensive, multifaceted approach to addressing barriers to learning.

In addition to an overview Survey of System Status, there are status surveys to help think about ways to address barriers to student learning by enhancing

- classroom-based efforts to enhance learning and performance of those with mild-moderate learning, behavior, and emotional problems
- support for transitions
- prescribed student and family assistance
- crisis assistance and prevention
- home involvement in schooling
- outreach to develop greater community involvement and support--including recruitment of volunteers
- Finally, included is a special survey focusing on School-Community Partnerships.

About the Self-Study Process to Enhance the Component for Addressing Barriers to Student Learning

This type of self-study is best done by teams.

However, it is *NOT* about having another meeting and/or getting through a task!

It is about moving on to better outcomes for students through

- working together to understand what is and what might be
- clarifying gaps, priorities, and next steps

Done right it can

- counter fragmentation and redundancy
- mobilize support and direction
- enhance linkages with other resources
- facilitate effective systemic change
- integrate all facets of systemic change and counter marginalization of the component to address barriers to student learning

A group of school staff (teachers, support staff, administrators) could use the items to discuss how the school currently addresses any or all of the areas of the component to address barriers (the enabling component). Members of a team initially might work separately in responding to survey items, but the real payoff comes from group discussions.

The items on a survey help to clarify

- what is currently being done and whether it is being done well and
- what else is desired.

This provides a basis for a discussion that

- analyzes whether certain activities should no longer be pursued (because they are not effective or not as high a priority as some others that are needed).
- decides about what resources can be redeployed to enhance current efforts that need embellishment
- identifies gaps with respect to important areas of need.
- establishes priorities, strategies, and timelines for filling gaps.

The discussion and subsequent analyses also provide a form of quality review.

Crisis Assistance and Prevention: Survey of Program Status

The emphasis here is on responding to,, minimizing the impact of,,and preventing crises. If there is a school-based Family/Community Center facility, it provides a staging area and context for some of the programmatic activity. Intended outcomes of crisis assistance include ensuring immediate assistance is provided when emergencies arise and follow-up care is provided when necessary and appropriate so that students are able to resume learning without undue delays. Prevention activity outcomes are reflected in the creation of a safe and productive environment and the development of student and family attitudes about and capacities for dealing with violence and other threats to safety. Please indicate all items that apply.

A. With respect to Emergency/Crisis Response:	Yes	Yes but more of this is needed	No	If no, is this something you want?
1. Is there an active Crisis Team?	___	___	___	___
2. Is the Crisis Team appropriately trained?	___	___	___	___
3. Is there a plan that details a coordinated response				
a. for all at the school site?	___	___	___	___
b. with other schools in the complex?	___	___	___	___
c. with community agencies?	___	___	___	___
4. Are emergency/crisis plans updated appropriately with regard to				
a. crisis management guidelines (e.g., flow charts, check list)?	___	___	___	___
b. plans for communicating with homes/community?	___	___	___	___
c. media relations guidelines?	___	___	___	___
5. Are stakeholders regularly provided with information about emergency response plans?	___	___	___	___
6. Is medical first aid provided when crises occur?	___	___	___	___
7. Is psychological first aid provided when crises occur?	___	___	___	___
8. Is follow-up assistance provided after the crises?	___	___	___	___
a. for short-term follow-up assistance?	___	___	___	___
b. for longer-term follow-up assistance?	___	___	___	___
9. Other? (specify) _____	___	___	___	___
B. With respect to developing programs to prevent crises, are there programs for				
1. school and community safety/violence reduction?	___	___	___	___
2. suicide prevention?	___	___	___	___
3. child abuse prevention?	___	___	___	___
4. sexual abuse prevention?	___	___	___	___
5. substance abuse prevention?	___	___	___	___
6. other (specify) _____	___	___	___	___

C. What programs are used to meet the educational needs of personnel related to this programmatic area?	Yes	Yes but more of this is needed	No	If no, is this something you want?
1. Is there ongoing training for team members concerned with the area of Crisis Assistance and Prevention?	___	___	___	___
2. Is there ongoing training for staff of specific services/programs?	___	___	___	___
3. Other? (specify) _____	___	___	___	___
D. Which of the following topics are covered in educating stakeholders?				
1. how to respond when an emergency arises	___	___	___	___
2. how to access assistance after an emergency (including watching for post traumatic psychological reactions)	___	___	___	___
3. indicators of abuse and potential suicide and what to do	___	___	___	___
4. how to respond to concerns related to death, dying, and grief	___	___	___	___
5. how to mediate conflicts and minimize violent reactions	___	___	___	___
6. other (specify) _____	___	___	___	___

E. Please indicate below any other ways that are used to provide crisis assistance and prevention to address barriers to students' learning.

_____ _____
_____ _____
_____ _____
_____ _____

F. Please indicate below other things you want the school to do to provide crisis assistance and prevention to address barriers to students' learning.

_____ _____
_____ _____
_____ _____
_____ _____

Topic 2: Crisis Response and Prevention: Programs that Work

Reading & Activity

		Page
Reading.	From: *A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning*, (pp. 48 (D-5) and Appendix D in original document).	38
Activity.	Use the various attached materials as stimuli and tools to focus application of what has been read	
	(1) *Write and discuss*: What does your school currently do to respond to and prevent crises? (use the attached worksheet as guide)	57
	(2) *What would you add?* (use the attached guide sheet and the accompanying sections from the self-study survey entitled: *Crisis Assistance and Prevention* as an aid)	58

Excerpt From

Mental Health in Schools Center
Training and Technical Assistance

Technical Assistance Sampler

A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning

This document is a hardcopy version of a resource that can be downloaded at no cost from the Center's website
http://smhp.psych.ucla.edu

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U.S. Department of Health and Human Services
HRSA
Health Resources and Services Administration
Maternal and Child Health Bureau

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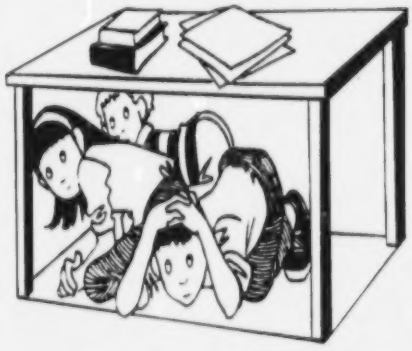
Center for Mental Health Services
SAMHSA

D. Crisis Response and Prevention

The emphasis here is on responding to, minimizing the impact of, and preventing crisis. Intended outcomes of crisis assistance include ensuring immediate assistance is provided when emergencies arise and follow-up care is provided when necessary and appropriate so that students are able to resume learning without undue delays. Prevention activity outcomes are reflected in the creation of a safe and productive environment and the development of student and family attitudes about and capacities for dealing with violence and other threats to safety.



Work in this area requires (1) systems and programs for emergency / crisis response at a site, throughout a school complex, and community-wide (including a program to ensure follow-up care), (2) prevention programs for school and community to address school safety/violence reduction, suicide prevention, child abuse prevention and so forth, and (3) relevant education for stakeholders.*

1. Crisis Team Response and Aftermath Intervention

2. School Environment changes and School Safety Strategies

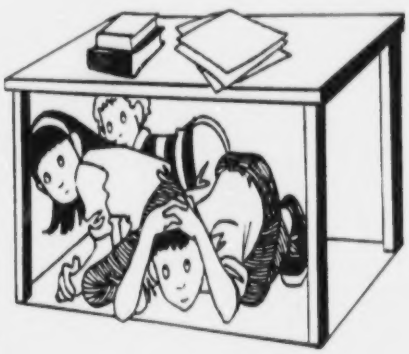
3. Curriculum Approaches to Preventing Crisis Events (Personal and Social)

- **a. Violence Prevention**
- **b. Suicide Prevention**
- **c. Physical/Sexual Abuse Prevention**

*The range of activity related to crisis response and prevention is outlined extensively in a set of self-study surveys available from our Center. (See Part VI for information on how to access these instruments.)

State of the Art for Crisis Response and Prevention

The need for crisis response and prevention is constant in some schools. Perhaps because few would argue against the importance of having crisis teams and crisis strategies in place before a crisis occurs, little attention has been given to testing the efficacy of such efforts. Also, relatively ignored has been the need for developing and evaluating aftermath interventions (e.g., for immediate debriefing, longer-term residual effects, PTSD). Most research in this area focuses on (a) programs to make the school environment safe as a key to deterring violence and reducing injury and (b) violence prevention and resiliency curriculum designed to teach children anger management, problem-solving skills, social skills, and conflict resolution. In both instances, the evidence supports a variety of practices that help reduce injuries and violent incidents in schools. However, given the nature and scope of preventable crises experienced in too many schools, greater attention must be devoted to developing and evaluating school-wide and community-wide prevention programs.*



*Given the pressure to compile outcome findings relevant to addressing barriers to student learning, as a first step we simply have gathered and tabulated information from secondary sources (e.g., reviews, reports). Thus, unlike published literature reviews and meta analyses, we have not yet eliminated evaluations that were conducted in methodologically unsound ways. We will do so when we have time to track down original sources, and future drafts of this document will address the problem as well as including other facets of intervention related to this area. In this respect, we would appreciate any information readers can send us about well-designed evaluations of interventions that should be included and about any of the cited work that should be excluded.

Table D. Crisis Response and Prevention

1. Crisis Teams, Response and Aftermath					
Title of Project/ Program *	Length of Evaluation	Target Population	Focus of Change	Outcomes	Nature of Academic Improvement
a. School Crisis Intervention Teams	1 year	All students	Students, Staff	Previous crisis drills conducted in a crisis intervention program prevented more deaths from occurring during an incident at Cleveland Elementary School where a gunman opened fire, killing 5 students.	None cited
b. School-Based Health Centers and Violence Prevention	Various project evaluations	Early, middle and high schools	Students	Fewer suicide attempts and fights on campus, improved attendance among truant/disruptive students, improvements in students' attitudes and behavior, and greater sense of school safety.	None cited
c. Project Rebound	Aftermath	All students	Students	Those in this short-term crisis therapy program reported that the counselors were supportive and allowed them to develop positive coping skills. Teachers reported greater student readiness to learn.	Teachers found that students who were involved in the program were more prepared to learn.
d. Research Studies					
>Cokeville School Bombing Study	Aftermath	All students	Students	Those students who participated most in group crisis discussion sessions recovered most quickly from a school bombing in Cokeville, WY.	None cited
>Experimental study with High School Seniors	Pre- and post-intervention evaluations plus a 1-year follow-up	Seniors in high school	Students	Those in a crisis coping program had scored significantly higher on self-efficacy and rational beliefs, and used more cognitive restructuring strategies when presented with a scene depicting a potentially traumatic transition.	None cited

* For more information on each program, project, or article, see Appendix D

Table D. Crisis Response and Prevention

2. School Environment Changes and School Safety Strategies					
Title of Project/Program *	Length of Evaluation	Target Population	Focus of Change	Outcomes	Nature of Academic Improvement
a. Westerly, Rhode Island: School District	Over a 4-year period	Students in all grades	Students, Families, Staff, School, School District	Reduced behavioral problems, schools safer and more productive for all students, dramatic drop in suspensions and other disciplinary incidents.	None cited
b. Center for the Prevention of School Violence	During Spring 1997	High Schools	School	36% of schools surveyed rated physical design and technology as highly effective for preventing violence in their schools. Of all surveyed safe school strategies, implementing school environment changes and/or using technology was rated as the 2nd highest effective strategy for preventing violence.	None cited
c. Playground Safety Studies					None cited
> *Community Intervention*	Over several years	Children, adolescents, families	School, Community	A multifaceted community intervention that refurbished park equipment and included safety programs for a target age group found decreased risk of injuries.	None cited
> *National SAFE KIDS Campaign*	Multiple years	Students	School, Community	Protective surfacing under and around playground equipment prevents and reduces the severity of playground fall-related injuries. Protective equipment, safe play conditions, and safety rules reduce the number and severity of sports- and recreation-related injuries.	
d. PeaceBuilders	3 years	K-5th grade	Students	Preliminary post-test results of ongoing CDC evaluation shows significant reductions in students' fighting-related injury visits to school nurse.	None cited

* For more information on each program, project, or article, see Appendix D

Table D. Crisis Response and Prevention

3. Curriculum Approaches to Preventing Crisis Events (Social and Personal)					
Title of Project/Program*	Length of Evaluation	Target Population	Focus of Change	Outcomes	Nature of Academic Improvement
3a. Violence Prevention **					
a-1. Second Step: A Violence Prevention Curriculum	Measures at pretest, after two weeks into program, and six-month follow-up	Preschool, elementary, and junior high school students	Students	Overall decrease in physical aggression and an increase in neutral/ prosocial behavior as compared to control groups. Effects persisted six months later.	None cited
a-2. Responding in Peaceful and Positive Ways (RIPP)	25 Weekly Sessions	6th graders	Students	Lower rate of fighting, bringing weapons to school and in-school suspension.	None cited
a-3. First Step to Success	Initial evaluation plus follow up for two years	K-3rd grade	Students, family, staff	Sustained changes in adaptive behavior, aggressive behavior, maladaptive behavior, and time spent in teacher-assigned tasks. Effects persist up to two-tears beyond end of intervention phase.	None cited
*a-4. Project ACHIEVE****	Since 1990	Elementary children with below average academic performance	Students, Family, Staff, School System	Dramatic drops in disciplinary referrals, disobedient behavior, fighting, and disruptive behavior. 75% decrease in referrals for at-risk students for special education testing. Suspensions dropped to 1/3 of what they had been three years before.	Reduction in grade retention and referral for special education.

* For more information on each program, project, or article, see Appendix D
** Other curriculum approaches for externalizing problems are covered in table A and multifaceted interventions including curriculum approaches are in part IV
*** Some multifaceted programs have been included here as well as in part IV

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Table D. Crisis Response and Prevention

3. Curriculum Approaches to Preventing Crisis Events (Social and Personal) (cont'd)					
Title of Project/Program*	Length of Evaluation	Target Population	Focus of Change	Outcomes	Nature of Academic Improvement
3a. Violence Prevention (cont'd) **					
a-5. Bullying Prevention Program	2 Years	Elementary, middle and junior high school students	Students, Family, Staff	Substantial reductions in boys' and girls' reports of bullying and victimization; in students' reports of general antisocial behavior (e.g., vandalism, fighting, theft and truancy); significant improvements in the "social climate" of the class.	None cited
a-6. Conflict Resolution and Peer Mediation Projects (CR/PM)	Various project evaluations	Various grades (K-12)	Students, Family, Staff	Reduced frequency of fighting and other undesirable behaviors at school, increased knowledge and modified student's attitudes about conflict, improved school discipline, and increased attendance.	None cited
a-7. *PeaceBuilders*	Three year study	Elementary school children	Students, Families, Staff	Dramatic drops in school suspensions and children arrested for crimes in the community.	None cited
a-8. Positive Adolescent Choices Training (PACT)	Ratings before and after training	At-risk youth ages 12-16	Students (especially African-American students)	Reduction in violence-related behavior, gains in skills predictive of future abilities to avoid violence.	None cited
a-9. Resolving Conflict CreativelyProgram (RCCP)	1988-1989 school year	Preschool-12th grade students	Students, Staff	Fewer fights and less frequent name-calling.	None cited

* For more information on each program, project, or article, see Appendix D

** Other curriculum approaches for externalizing problems are covered in table A and multifaceted interventions including curriculum approaches are in part IV

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Table D. Crisis Response and Prevention

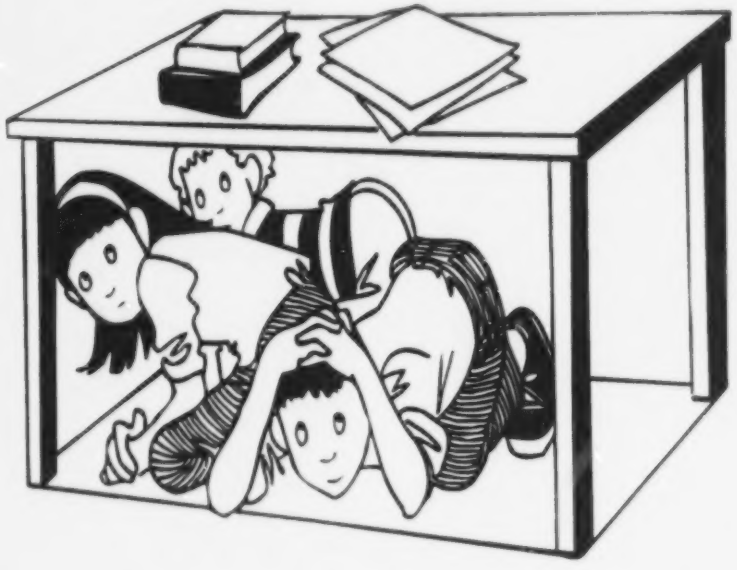
3. Curriculum Approaches to Preventing Crisis Events (Social and Personal) (cont'd)					
Title of Project/Program*	Length of Evaluation	Target Population	Focus of Change	Outcomes	Nature of Academic Improvement
3a. Violence Prevention (cont'd) **					
a-10. Meditation in the Schools Program	Multiple evaluations, one each year	at-risk students	Students, Staff, Special Curriculum	Students were more in control and empowered, and exhibited higher self-esteem. Staff reported decreases in violence since the program's inception, and teachers witness less violence among students.	None cited
a-11. Lions-Quest Working Toward Peace	Varied	Students grades 6-8, teacher, principals and parents	Systemic changes	Improved school climate, fewer discipline referrals, a safer school environment, and increased family and community involvement.	None cited
a-12. Michigan Model for Comprehensive School Health Education	Varied	Students grades K-12	Students, parents and teachers	Positive impact in curtailing rates of alcohol, tobacco and marijuana use in middle school students (designated as one of the top substance abuse and violence prevention programs in US).	None cited
3b. Suicide Prevention					
b-1. Suicide Prevention Project 1	12 weeks	8th graders	Students	Increased empathy, reduced suicidality.	None cited
b-2. Suicide Prevention Project 2	7 weeks	11th graders	Students	Reduced suicidal tendencies	None cited
3c. Physical / Sexual Abuse Prevention					
Good Touch/Bad Touch Program	3 sessions	Pre-school to sixth-grade students	Student	Results show significant improvement in children's ability to recognize abuse and to know what to do if it occurred.	None cited

* For more information on each program, project, or article, see Appendix D

** Other curriculum approaches for externalizing problems are covered in table A and multifaceted interventions including curriculum approaches are in part IV

Appendix D: Crisis Response and Prevention

The following are brief summaries and related information on the crisis response and prevention programs listed in Table D.



1. Crisis Teams, Response and Aftermath

a. *School Crisis Intervention Team:* Poland and Pitcher (1990) described how conducting crisis drills legitimized the crisis intervention program. Also, they emphasize crisis drills because students are not going to do what you need them to do in a moment of crisis unless you have practiced it with them and have clearly emphasized the need for students to follow the directives of an adult with no questions asked. For example, Cleveland Elementary School had a policy of conducting crisis drills on their playground. In 1989, a gunman opened fire on students and teachers on the playground, killing 5 students. Researchers report that the crisis drills conducted on that very playground prevented more deaths from occurring. The school also provided facts to everyone involved and were able to accommodate cultural and language barriers in their debriefing procedures.

For more information, see:
Poland, S. (1994). The role of school crisis intervention teams to prevent and reduce school violence and trauma. *School Psychology Review, 23*, 175-189.

Poland, S. & Pitcher, G. (1990). Best practices in crisis intervention. In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology* (Vol. 2, pp. 259-275). Washington, DC: National Association of School Psychologists.

b. *School-Based Health Centers and Violence Prevention*: Three community health centers--in West Virginia, Maryland, and California--developed projects to improve and increase violence prevention and mental health services through school-based health clinics. Each site developed its own package of mental health/violence prevention services to meet the need of its clients and community, and address local issues related to violence. Since the mental health centers were implemented, all three sites reported fewer suicide attempts, fewer fights on campus, and improved attendance among previously truant students or those with discipline problems. Teachers and staff also report general improvements in students' attitudes and behavior, and a greater use of conflict resolution tools by students. Both teachers and students also report a greater sense of school safety.

For more information, see:
Healing Fractured Lives: How Three School-Based Projects Approach Violence Prevention and Mental Health Care. Bureau of Primary Health Care, U.S. Department of Health and Human Services.

c. *Project Rebound*: Project Rebound is a 10 week art therapy program designed to help children who have experienced a crisis express concerns, fears, anxieties, anger and helplessness in a safe and supportive environment. Student report that the counselors are supportive and allowed them to develop positive coping skills. Teachers found that students who were involved in the program were more prepared to learn.

For project information, contact:
The Psychological Trauma Center, 8730 Alden Drive, Room C-106A, Los Angeles, CA 90048, (310) 855-3506.

d. Research Studies

Cokeville School Bombing Study: Following a school bombing in Cokeville, WY, the school administrator took steps to manage the crisis and provide leadership to the community. Students returned to school the next day, and attended meetings with other students and parents where they had an opportunity to discuss their feelings and concerns in an open, safe forum. Those students who participated most in the group sessions recovered most quickly.

For more information, see:
Sandall, N. (1986). Early Intervention in a disaster: The Cokeville hostage/bombing crisis. *Communique, 15, 1-2.*

Poland, S. (1994). The role of school crisis intervention teams to prevent and reduce school violence and trauma. *School Psychology Review*, 23, 175-189.

Experimental Study with High School Seniors: Fifty-seven high school seniors were provided with graded crisis experiences to work through under circumstances that favored successful outcomes. Three types of coping strategies, including relaxation, cognitive restructuring, and problem solving, were provided to help them deal with the crisis experiences. Following participation in the 6-week program, participants, as opposed to those in a control group, evidenced significantly higher scores on tests measuring self-efficacy and rational beliefs. When presented with a scene depicting a potentially traumatic transition at the end of the program, participants (compared to controls) used significantly more cognitive restructuring strategies.

For more information, see:
Jason, L.A., & Burrows, B. (1983). Transition training for high school seniors. *Cognitive Therapy and Research*, 7, 79-91.

2. School Environment Changes and School Safety Strategies

a. *Westerly School District (RI)*: The Westerly school district went from having 100 Office of Civil Rights violations to becoming a model program for students who are receiving a continuum of support services for behavioral problems. Policies were restructured to emphasize both prevention and intervention. Over a 4-year period, behavioral problems were reduced, self-contained classrooms for students with emotional and behavioral problems were reduced from 13 in 1990 to only 2 in 1994, and the schools became safer and more productive for all students, at all levels: elementary, middle and high schools. Compared to other Rhode Island districts, when one divides the total number of suspensions by the total student enrollment, Westerly's index is .038, compared to the state index of .232. Similarly, the index for disciplinary incidents in Westerly is .05 compared to .09 and .31 for other Rhode Island districts similar to Westerly in size and demographics.

For more information, see:
Keenan, S., McLaughlin, S., & Denton, M. (1995). *Planning for inclusion: Program elements that support teachers and students with emotional/behavioral disorders*. Highlights from the Second Working Forum on Inclusion. Reston, VA: Council for Children with Behavioral Disorders.

Quinn, M. M., Osher, D., Hoffman, C. C., & Hanley, T. V. (1998). *Safe, drug-free, and effective schools for ALL students: What works!* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

For project information, contact:
Mark Hawk, Director of Special Education, Westerly Public Schools, 44 Park Ave, Westerly, RI 02891-2297, (401) 596-0315.

b. *Center for the Prevention of School Violence (CPSV)*: According to the CPSV, preventing school violence through assessing physical design and, if necessary, using technology (like metal detectors or cameras) offers a strategy that enables school officials to provide safe and secure learning environments in which students can achieve and succeed. The CPSV conducted a telephone survey of all high schools in North Carolina during Spring, 1997, to determine which safety and security strategies are being used in these schools. Almost 74% of schools participating in the survey have performed assessments of their physical layouts. In addition to controlling access to school, 80% implement some kind of parking lot security. In terms of maintaining control, various types of policies exist with hall monitoring, occurring at 88% of the schools, and campus identification tags and book-bag policies, newer forms, in place at 19% of the schools. 60% of the schools have metal detectors with 64% using one or two of them. Of the schools with metal detectors, 90% have portable ones, 16% have stationary ones located at the entrances of football stadiums. The frequency of use varies with 4% using them daily and 62% using them randomly. 12% have them but never use them. Most schools do not have surveillance cameras; only 24% use such cameras. Other technologies applied to make schools safe and secure include two-way radios, identified by 22% of the schools, and alarm systems, identified by 10% (These numbers may be low given that the other technologies were not specifically asked about.). Two schools indicated that they have Breathalysers. Using a seven-point scale with "one" representing a perceived highest level of effectiveness and "seven" a perceived lowest level, improving safety through changes in the physical design of the school and use of technology was rated by

respondents. Almost thirty-six percent of respondents rated physical design and technology a "one" or "two" indicating their perception that, for their schools, effectiveness on preventing violence is high with reference to this strategy. Only sixteen percent rated it "six" or "seven," reflecting low effectiveness. Also, of all of the safe school strategies surveyed, implementing changes in the physical school environment and/or utilizing technology was rated as the second highest effective strategy out of six strategies (including peer mediation & conflict management, S.A.V.E., law-related education, teen/student court, and having a school resource officer). Having a school resource officer was listed as the most effective strategy.

For more information, contact:
Center for the Prevention of School Violence, Dr. Pamela L. Riley, Executive Director, 20 Enterprise Street, 2, Raleigh, North Carolina 27607-7375, 1-800-299-6054 or 919-515-9397, Fax: 919-515-9561 or download a summary from www.ncsu.edu/cpsv/

c. *Playground Safety Studies*: A multi-faceted community intervention (starting in 1989) including: repair of all playgrounds major capital improvements in 5 playgrounds and parks, painting of building murals, development of recreational programs for target age group, traffic safety programs and bicycle helmet promotion was implemented in Central Harlem and Washington Heights. Across time, this program showed a decrease in the risk of all injuries in the target age group in Central Harlem and in Washington Heights (compared to a younger, non-targeted group). However, there was no decrease in outdoor fall injuries in the target age group.

For more information, see:
Davidson, L.L., Durkin, M.S., Kuhn, L., O'Connor, P., Barlow, B., & Heagarty, M.C. (1994). The impact of the Safe Kids Health Neighborhoods Injury Prevention Program in Harlem, 1988 through 1991. *American Journal of Public Health, 84*, 580-586.

National SAFE KIDS Campaign reports that protective surfacing under and around playground equipment can reduce the severity of and even prevent playground fall-related injuries. In addition, protective equipment, safe play conditions (e.g., field surfacing, maintenance) and development and enforcement of safety rules help reduce the number and severity of sports and recreation-related injuries.

For more information, contact:
The National SAFE KIDS Campaign, 1301 Pennsylvania Ave, NW, Suite 1000, Washington, DC 20004-1707, (202)662-0600, (202) 393-2072 Fax, http://www.safekids.org, info@safekids.org

d. *PeaceBuilders*: PeaceBuilders, is a K-5 program of Heartsprings, Inc. in Tucson, AZ. The program emphasizes praising others, avoiding negative comments, being aware of injustices, righting wrongs and seeking out "wise people." The program offers excellent classroom management suggestions, particularly for handling discipline and "unruly" kids. The program also contains many extras including an intensive peace building program for especially disruptive students, a family program, playground program, planning guides for teachers, a leadership guide for administrators, manuals for school staff, bus drivers, cafeteria workers, etc. Preliminary post-test results of rigorous ongoing CDC evaluation shows significant reductions in fighting- related injury visits to school nurse by students.

For more information see:
Safe Schools, Safe Students: A Guide to Violence Prevention Strategies. (1998). Drug Strategies, Washington, D.C.

School Health Starter Kit, Association of State and Territorial Health Officials, 1275 K. St. NW, Suite 800, Washington, DC 20005. (202)371-9090.

3. Curriculum Approaches to Preventing Crisis Events (Social and Personal)

3a. Violence Prevention

a-1 *Second Step: A Violence Prevention Curriculum*: Second Step is a school-based social skills curriculum for preschool through junior high that teaches children to change the attitudes and behaviors that contribute to violence. Second Step teaches the same three skill units at each grade level: Empathy, Impulse Control, and Anger Management. Lesson content varies according to the grade level, and the skills practiced are designed to be developmentally appropriate. There were no significant teacher- or parent-reported differences between those students participating in Second Step and a control group. However, two-weeks after the intervention was completed behavioral observations revealed that students in Second Step showed an overall decrease in physical aggression, and an increase in neutral/prosocial behavior, compared to the control group. Most of these effects persisted six months later.

For more information, see:

Grossman, D.C., Neckerman, H.J., Koepsell, T.D., Liu, P. Asher, K.N., Beland, K., Frey, K., & Rivara, F.P. (1997). Effectiveness of a violence prevention curriculum among children in elementary school: A randomized controlled trial. *Journal of the American Medical Association*, 277(20), 1605-1611.

Quinn, M. M., Osher, D., Hoffman, C. C., & Hanley, T. V. (1998). Safe, drug-free, and effective schools for ALL students: What works! Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

For project information, contact:

Second Step: A Violence Prevention Curriculum: Committee for Children, 2203 Airport Way South, Suite 500, Seattle, WA 98134. (800) 634-4449, (206) 343-1223.

a-2 *Responding in Peaceful and Positive Ways (RIPP) Program:* The 25 session RIPP program focuses on social/cognitive skill-building to promote nonviolent conflict resolution and positive communication. The 25-session sixth grade curriculum is taught during a 45-minute class period once a week. Participants showed significantly lower rates of fighting, bringing weapons to school, and in-school suspensions than control subjects.

For project information, contact:

Farrell, A.D. & Meyer, A.L., & Dahlberg, L.L. (1996). The effectiveness of a school-based curriculum for reducing violence among urban sixth-grad students. *American Journal of Public Health*, 87, 979-984

Farrell, A.D., Meyer, A.L. & Dahlberg, L.L. (1996). Richmond youth against violence: A school based program for urban adolescents. *American Journal of Preventive Medicine*, 12, 13-21.

Farrell, A.D. & Meyer, A.L. (in press). Social Skills Training to Promote Resilience in Urban Sixth Grade Students: One product of an action research strategy to prevent youth violence in high-risk environments. *Education and Treatment of Children*.

a-3 *First Step to Success:* An early intervention program for grades K-3 that takes a collaborative home and school approach to diverting at-risk children from a path leading to adjustment problems, school failure and drop-out, social juvenile delinquency in adolescence, and gang membership and interpersonal violence. By recruiting parents as partners with the school, this program teaches children a behavior pattern that contributes to school success and the development of friendship. Children are screened for antisocial behavior, they participate in a social skills curriculum, and parents are taught key skills for supporting and improving their child's school adjustment and performance. Students who successfully complete the program show sustained behavior changes in the following areas, as indicated by teacher ratings and direct observations: adaptive behavior, aggressive behavior, maladaptive behavior, and the amount of time spent appropriately engaged in teacher-assigned tasks. Follow-up studies show that intervention effects persist up to two-years beyond the end of the initial intervention phase.

For more information, see:

Walker, H.M. (1998). First step to success: Preventing antisocial behavior among at-risk kindergartners. *Teaching Exceptional Children,* 30(4), 16-19.

Walker, H.M., Severson, H.H., Feil, E.G., Stiller, B., & Golly, A. (1997). *First step to success: Intervening at the point of school entry to prevent antisocial behavior patters.* Longmont, CO: Sopris West.

Walker, H.M., Stiller, B., Severson, H.H., Kavanagh, K., Golly, A., & Feil, E.G. (in press). First step to success: An early intervention approach for preventing school antisocial behavior. *Journal of Emotional and Behavioral Disorders,* 5(4).

For program information, contact:

Jeff Sprague & Hill Walker, Co-Directors, Institute on Violence and Destructive Behavior, 1265 University of Oregon, Eugene, OR 97403. (541) 346-3591

a-4 *Project ACHIEVE:* A school wide prevention and early intervention program, that targets students who are academically and socially at risk. Students learn social skills, problem-solving methods, and anger-reduction techniques. Since 1990, the program has reduced aggression and violence in Project ACHIEVE schools. Disciplinary referrals decreased by 67%. Specifically, referrals for disobedient behavior dropped by 86%, fighting by 72% and disruptive behavior by 88%. Referrals for at-risk students for special education testing decreased 75% while the number of effective academic and behavioral interventions in the regular classroom significantly increased. Suspensions dropped to one-third of what they had been three years before. Grade retention, achievement test scores, and academic performance have improved similarly, and, during the past four years, no student has been placed in the county's alternative education program. The project's success has led to the adoption of the Project ACHIEVE model in over 20 additional sites across the United States.

For more information, see:

Knoff, H.M. & Batsche, G. M. (1995). Project ACHIEVE: Analyzing a school reform process for at-risk and underachieving students. *School Psychology Review, 24*(4), 579-603.

Knoff, H.M. & Batsche, G. M. *Safe Schools, Safe Students.* Edited by Ronda C. Talley & Garry R. Walz. National Education Goals Panel and National Alliance of Pupil Services Organizations. Produced in collaboration with ERIC Counseling and Student Services Clearinghouse.

Quinn, M. M., Osher, D., Hoffman, C. C., & Hanley, T. V. (1998). *Safe, drug-free, and effective schools for ALL students: What works!* Washington, DC: Center for Effective Collaboration and Practice, American Institutes for Research.

For project information, contact:

Drs. Howie Knoff and George Batsche, Co-Directors, Institute for School Reform, Integrated Services,

and Child Mental Health and Education Policy, School Psychology Program, FAO 100U, Room 268. The University of South Florida, Tampa, FL 33620-7750, (813) 974-3246.

a-5 *Bullying Prevention Program*: A universal intervention for the reduction and prevention of bully/victim problems. The main arena for the program is the school, and school staff has the primary responsibility for the introduction and implementation of the program. Program targets are students in elementary, middle, and junior high schools. All students within a school participate in most aspects of the program. Additional individual interventions are targeted at students who are identified as bullies or victims of bullying. The Bullying Prevention Program has been shown to result in: a substantial reduction in boys' and girls' reports of bullying and victimization; a significant reduction in students' reports of general antisocial behavior such as vandalism, fighting, theft and truancy; and significant improvements in the "social climate" of the classes as reflected in students' reports of improved order and discipline, more positive social relationships, and a more positive attitude toward schoolwork and school.

For more information, contact:
Dan Olweus, Ph.D., University of Bergen, Research Center for Health Promotion (HEMIL), Christiesgt. 13, N-5015, Bergen, Norway, 47-55-58-23-27, E-mail: olweus@psych.uib.no

a-6 *Conflict Resolution and Peer Mediation Projects (CR/PM)*: Nine CR/PM programs throughout the country were evaluated. Data from this evaluation suggests that CR/PM projects may reduce the frequency of fighting and other undesirable behaviors at school, increase knowledge and modify student's attitudes about conflict, improve school discipline, and increase attendance. However, these findings are based on preliminary data, and success varies depends on how the curriculum is implemented.

For more information, see:
Altman E. (1994). *Violence Prevention Curricula: Summary of Evaluations.* Springfield, Ill: Illinois Council for the Prevention of Violence.

Powell, K. E., Muir-McClain, L., & Halasyamani, L. (1995). A review of selected school-based conflict resolution and peer mediation projects. *Journal of School Health, 65* (10), 426-431.

Tolan, P. H. & Guerra, N. G. (1994) *What Works in Reducing Adolescent Violence: An Empirical Review of the Field.* Boulder, CO: Center for the Study and Prevention of Violence.

a-7 *PeaceBuilders:* A school-wide violence prevention program for elementary schools (K-5). This program is designed to prevent violence by reducing students' hostility and aggression by changing the school climate and promoting prosocial behavior. The project involves norm-setting, peace-building, and communication skills development. It reinforces prosocial behavior and enhances parent education and involvement, and includes mass media tie-ins. A year before PeaceBuilders began, 120 children were suspended and about 30 were arrested for crimes in the community. Two years into PeaceBuilders, the number of suspensions had dropped to five, and there were no arrests for community crimes. One school using the PeaceBuilders program reported that major student fights dropped from 125 to 23; another school reported a decrease from 180 to 24. Outcome assessments are still underway.

For more information, see:
Embry, D.D., Flannery, D.J., Vazsonyi, A.T., Powell, K.E., & Atha, H. (1996). PeaceBuilders: A theoretically driven, school-based model for early violence prevention. American Journal of Preventive Medicine. Youth Violence Prevention: Description and Baseline Data from 13 Evaluation Projects (Supp.), 12 (5), 91-100.

Walker, H.M., Colvin, G., Ramsey, E. (1995). *Anti-Social Behavior in Schools: Strategies and Best*

Practices. Pacific Grove, California: Brooks/Cole.

For program information, contact:
Jane Gulibon, Heartsprings, Inc., P.O. Box 15258, Tuscon, AZ 85732, (520) 322-9977.

a-8 *Positive Adolescent Choices Training (PACT):* Designed to reduce the chances that African-American and other at-risk adolescents will become victims or perpetrators of violence. Primarily targets youth between 12 and 16 identified as socially deficient or with a history of violence. Participants receive hands-on training and practice in 3 areas: prosocial skills, anger control, and violence risk education. Data suggest that those who completed the program showed reduced violence-related behavior as well as gains in skills predictive of future abilities to avoid violence. The data also suggest that others perceived the trained participants to have improved social skills and that trainees themselves had more confidence in their abilities to perform the new behaviors.

For more information, see:
Hammond, W.R., & Yung, B.R. (Winter, 1991). Preventing violence in at-risk African-American Youth. *Journal of Health Care for the Poor and Underserved*, 359-373.

For program information, contact:
B. Yung, Center for Child and Adolescent Violence Prevention, Wright State University, Ellis Human Development Institute, 9 N. Edwin C. Moses Blvd, Dayton, OH 45407, (937) 775-4300.

a-9 *Resolving Conflict Creatively Program (RCCP):* Curriculum stresses modeling of nonviolent alternatives for dealing with conflict and teaches negotiation and other conflict resolution skills. Conflict resolution and communication skills are taught in the classroom and practiced at least once a week. Several students are trained as "mediators" to assist others in resolving conflicts. Teachers who participate report decreases in name-calling and physical violence among students. When students are tested, most learn the key concepts of conflict resolution and are able to apply them when responding to hypothetical conflicts. In addition, students themselves have reported getting in fewer fights and engaging less frequently in name-calling compared with matched control groups. For the peer mediation component, 80% of students and teachers report that students are helped by contact with mediators. Nine out of ten teachers who participated in the program said that they had improved understanding of children's needs and were more willing to let students take responsibility for resolving their own conflicts.

For more information, see:
DeJong, W. *Building the Peace: The Resolving Conflict Creatively Program (RCCP)*. National Institute of Justice: Program Focus. US Dept. Of Justice, Office of Justice Programs.

For project information, contact:
Linda Lantieri, RCCP National Center, 163 3rd Ave, Room 103, New York, NY 10003, (212) 387-0225.

a-10 *The Mediation in the Schools Program:* Promotes positive resolution of conflict in schools. The program consists of three components: conflict management curriculum for the classroom; adult modeling of mediation in conflict resolution; and training of student mediators to provide mediation services to other students. Evaluation showed that the program seemed to be "owned" by the students. Students were described as being more in control and empowered, as well as exhibiting higher self-esteem. Coordinators and administrators reported decreased levels of violence since the introduction of the program. Program teachers perceived less violence and hurtful behaviors among students believed that the program was effective in teaching students alternative, positive dispute resolution strategies and in decreasing levels of violence at school.

For more information, see:
Carter, S.L. Evaluation report for the New Mexico center for dispute resolution. *Mediation in the Schools Program, 1993-1994 school year*. Albuquerque: New Mexico Center for Dispute Resolution, 1994.

Lam, J.A. *The impact of conflict resolution programs on schools: A review and synthesis of the evidence*. Amherst, Mass.: National Association for the Mediation in Education, 1988.

For program information, contact:
National Resource Center for Youth Mediation, New Mexico Center for Dispute Resolution 620 Roma NW, Suite B, Albuquerque, NM 87102, (505)247-0571 / fax: (505)242-5966

For evaluation information, contact:
Susan Lee Carter, Ph.D. P.O. Box 67 Cerrillos, NM 87010, (505)424-0244

3-b Suicide Prevention

b-1 Project I: Demonstrated positive effects on suicide risk for junior-high students in Israel. In a randomized trial with 237 8th grade students, the 12-week group cognitive-behavioral program produced significant reductions in suicides, as measured by the culturally adapted Israeli Index of Potential Suicide (IIPS), among treatment boys. Effects for girls on the IIPS did not reach the level of significance.

For more information, contact:
Klingman, A., & Hochdorf, Z. (1993). Coping with distress and self-harm: The impact of a primary prevention program among adolescents. *Journal of Adolescence. 16*, 121-140.

b-2 Project 2: Demonstrated a significant reduction in suicides, in this case among 11th grade students from 6 high schools in Israel. This program was evaluated in a randomized trial examining 393 students (including some conduct disordered students). Across all schools, the authors report significant effects on suicidal tendencies, coping skills, and ego identity.

For more information, contact:
Orbach, I., & Bar-Joseph, H. (1993). The impact of a suicide prevention program for adolescents on suicidal tendencies, hopelessness, ego identity and coping. *Suicide and Life-Threatening Behavior, 23*(2), 120-29.

3-c Physical/Sexual Abuse Prevention: Program is a child abuse prevention program for preschool aged to sixth-grade students. Developed in 1984 in Geogia, the goal of the program is to prevent or stop child abuse and to reduce the trauma associated with it. The curriculum includes accurate, age-appropriate information and helpful strategies to limit emotional and sexual abuse. Modifications have been made for the developmentally delayed. Evaluation results from this small sample suggest that children as young as kindergarten age can learn knowledge and skills for the prevetnion of sexual abuse.

For program information, contact:
Pam Church, director, Prevention and Motivation Programs, Inc., P.O. Box 1960 659 Henderson Dr, suite H, Cartersville, GA 30120, phone(800)245-1527 / fax: (770)607-9600

For evaluation information, contact:
Rex Forehand, Ph.D., Dept of Psychology, University of Georgia, Athens, GA, phone (706)549-0541

Worksheet

Write and Discuss
Crisis Assistance and Prevention – What Does Your School Do?

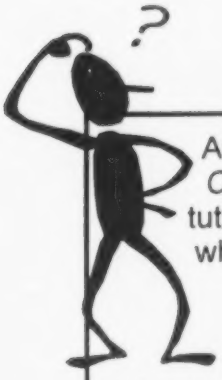
(1)What does your school currently do to respond to and prevent crises?

(2) How adequate are the current measures? (And, if they are not satisfactory, why is this case?)

(3) From what you have learned so far, what's missing?

Source: UCLA Center for Mental Health in Schools; Los Angeles, CA 90095-1563 (310) 825-3634; smhp@ucla.edu

What would you add?



Attached are sections from a self-study survey entitled: *Crisis Assistance and Prevention.* For purposes of this tutorial, just read over the items. These provide a sense of what might take place at a school.

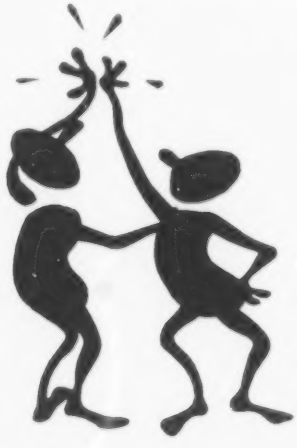
After reviewing the items, list below any additional activities you think you would want in place at your school to enhance the school's efforts to respond to and prevent crises.

The survey itself can be used at a school in a number of ways (see the introductory page entitled: "About the Self-Study Process to Enhance the Component for Addressing Barriers to Student Learning").

Topic 3 : Effective Crisis Team Leadership to Prevent Crises and thus Reduce Disruptions to Learning

Reading & Activity

		Page
Reading.	From: *Responding to a Crisis at a School*, Section IV "Organizing and Training a School-Based Crisis Team" (pp. 45 - 51d in original document).	59
Activity.	Use the various attached materials as stimuli and tools to focus application of what has been read	
	(1) *School observation*: Improving Crisis Response and Prevention (see attached worksheet)	69
	(2) *Making the case for improving crisis response and prevention in order to enhance the environment for learning* (see attached worksheet).	70



Section IV

Organizing and Training a School-based Crisis Team

- **Building a School-Based Crisis Team**
- **Crisis Team Training**
- **Two Initial Training Sessions**

Building a School-Based Crisis Team

The process of organizing a school-based crisis team begins with the site's leadership. Once there is agreement on the value of establishing such a team, someone must be designated the responsibility of building the team. That person begins by identifying those who have formal roles they must play during a crisis, those with specific skills that are needed, and any others who may be especially motivated to be part of such a team.

The next step is to set a meeting time and invite the potential members.

To increase the likelihood that the meeting is focused and productive, it helps to do some presession structuring. This includes

- ✓ asking others to play a role during the meeting (e.g., meeting facilitator, time keeper, note taker --see accompanying sample form)
- ✓ providing them with copies of the site's existing crisis response plans and some general material to read on the subject of school-based crisis response (such as the overview presented in Section I of this resource aid).

During the meeting, it helps to use worksheets that focus the discussion on key topics and decisions about tasks assignments and timelines.

The meeting, of course, will review the site's existing crisis response plans and discuss a variety of related matters.

By the end of the meeting, agreements should have been made about team membership, roles, and decide on initial training dates and who will conduct the training.

Example of Meeting Invitation

Meeting to Organize the School's Crisis Response Team

Date

To:

From:

As you know the school has decided to (re)organize a school-based crisis team. You have been identified as a key person to talk with about the team.

At the meeting, we will review the site's existing crisis response plans and discuss a variety of related matters. By the end of the meeting, we will clarify crisis team membership, roles, and initial training dates.

In preparation for our meeting, please review the attached material.

The meeting is scheduled for (date, day, time)

To help make the meeting run smoothly and productively, the following staff have agreed to guide the process.

Meeting facilitator will be_____

Meeting time keeper will be_____

Meeting scribe will be_____

Finally, since a crisis demands that we work quickly, teamwork under pressure will be good practice. This means starting and ending the meeting on time and setting time limits for each task.

Session Topic:

FOCUS ON PLANNING

What are our roles and functions as team members?

(1) Meeting facilitator reviews the key team roles and functions

(2) Decide who will take each role. (Fill in Worksheet -- see accompanying example).

> If there are enough people, designate a back up for each position. Discuss *chain of command*. Who will be in charge, who will be next, if these two are not available or busy who would be third. Enter all necessary contact information (e.g., home numbers, beepers).

(3) Discuss the last crisis at the school.

> If one doesn't come to mind, use the possibility of a car accident outside school involving a student and observed by most students and parents. Each team member should assume her/his role in talking through the specifics of what to do. Treat this as brainstorming with no discussion until the exercise is finished. Then take five minutes to highlight the good ideas and additional suggestions for action.

(4) Plan on a way each team member will inform others at the school about the crisis team membership and roles. For examples who will talk to faculty, parent center coordinator, office staff, TA's, Playground staff, support staff?

(5) Prepare for the next meeting which will *FOCUS ON ACTION*

Date for next meeting
Meeting facilitator
Meeting time keeper
Meeting scribe

> Someone should volunteer to copy and distribute the preparation material for the next meeting.

Worksheet

Team Membership, Roles, and Functions

Roles Functions	*Name* (One person may serve more than one role/function)	*Chain of Command* (Who's in charge? Back-ups?)	*Contact Information*
Team Leader			
Administrative Liaison			
Staff Liaison			
Communications Liaison			
Media Liaison			
First Aid Coordinator(s) medical psychological			
Communications Coordinator			
Crowd Management Coordinator			
Evacuation/Transportation Coord.			

Crisis Team Training

The team as a whole should receive general training with respect to crisis intervention and team building. In addition, each subteam or designated "specialist" needs specialized training.

> The team leader should bring all members together once a month so that each can learn from the experiences and training of the others. The minutes of this meeting can be reproduced as a monthly report to the school, and this report can act as a reminder of the importance of dealing with the aftermath of crises, of who should be contacted at such times, and as an indication of the team's impact.

Besides mastering the school's crisis response plan and emergency steps, *general* training involves learning

- how to minimize student contagion in the aftermath of such a problem
- how to reassure the majority of students about the problem
- how to identify and provide psychological first aid to students who have especially strong reactions (including assisting with someone in acute shock or trauma)
- counseling skills appropriate to the event (including active listening skills, small-group techniques for both students and adults, conflict resolution, critical incident stress debriefing, support group facilitation)

Each subteam should receive *specialized* training with respect to the specific type of crisis with which the subteam is concerned (e.g., fire, earthquake, suicidal youth). Specialized training involves learning

- the types of reactions students, staff, and parents are likely to have to a particular type of crisis;
- how to respond to specific types of reactions.

> Note: A special training opportunity for interested team members is to participate in a disaster drill held by local hospitals, police, fire departments, offices of emergency services, etc.

Two Initial Training Sessions

The first sessions after the organizational meeting stress specific preparation for action and prevention..

Session 1: **FOCUS ON ACTION**

What steps should we plan for?

Session 2: **FOCUS ON PREVENTION**

How can we enhance resources to prevent some crises and minimize others?

(1) Focus on Action

Prior to the session, team members are to review the material on Planning for Crisis in Section I of this resource aid, as well as the material on key considerations and the Crisis Checklists contained in Section II.

At the session(s):

1) The meeting facilitator talks through a crisis intervention flow chart. For each step, team members write in the name(s) of who on the team will be responsible for the function.

2) The meeting facilitator asks each member to talk through one section of the checklist. Briefly personalize this for the school (who, what, when, where). If this takes too long for one meeting, carry if over to a second FOCUS *ON ACTION* Meeting.

3) If there has been a crisis at the school or one has been averted or minimized, discuss it briefly. Assess what worked well and what didn't. Make any changes in the plans and decide how to inform others.

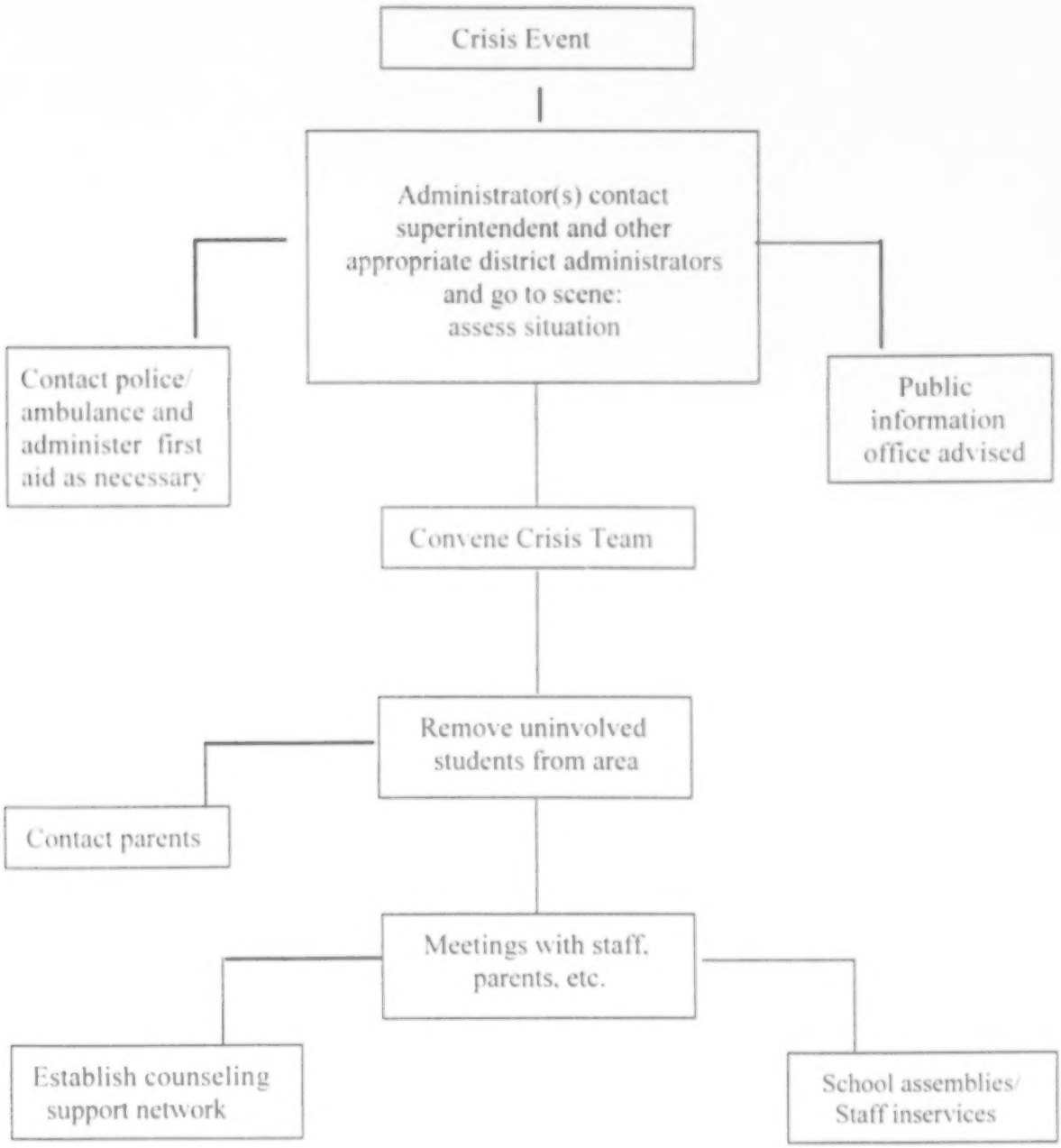
Preparation for the next meeting *FOCUS ON PREVENTION*.

Date of the meeting: Meeting time keeper:

Meeting facilitator: Meeting scribe:

Crisis Intervention Flow Chart

Personal/Life Threatening Event


Crisis Event
Administrator(s) contact superintendent and other appropriate district administrators and go to scene: assess situation
Contact police/ ambulance and administer first aid as necessary
Public information office advised
Convene Crisis Team
Remove uninvolved students from area
Contact parents
Meetings with staff, parents, etc.
Establish counseling support network
School assemblies/ Staff inservices

(2) Focus on Prevention

At this session(s), the discussion and training explores the following matters.

If a crisis situation has occurred at the school, part of the time is used for debriefing (*What happened? How was it handled? What went well? What didn't? Is a change in plans needed?*).

To begin to plan ways to minimize and perhaps avert crises, the team needs to understand how existing programs might be enhanced and new ones developed. The discussion begins with the questions:

What are ways the school can avert or minimize crisis situations?

Can we do so by enhancing certain programs and developing preventive approaches?

This leads to discussion of:

What does the school have? Need?

What else might strengthen the safety net?

In this context, team members can learn to map what's in place and analyze whether it needs to be improved (e.g., Is the school's emergency plan effective? Is there a safe school plan? a Parent Center? a District Crisis Team? Is there a conflict mediation program? a human relations program? Could linkage with some community resources result in better recreation and enrichment opportunities and reduce gang violence?)

With a view to enhancing resources for all facets of crisis response and prevention, team members need to connect with community resources. As a first step, they can begin by mapping resources that can assist during and in the aftermath of a crisis (see attached worksheet).

Future training sessions should try to achieve a balance between capacity building for crisis response and pursuing ideas for crisis prevention. In terms of timing, everyone tends to be most motivated to learn in the wake of a debriefing done after a crisis. For purposes of simulated practice, the team might use any disaster drills the school carries out (e.g., fire, earthquake). As new members join, it is a good opportunity for experienced members to orient and teach them and, in the process, to review and consolidate what they have learned to date.

Starting to Map Community Resources

What resources are available in the school district and community to assist during and after a crisis? List all the community resources you know about. (Consult any resource books and look in the local phone book.)

Divide up the list and contact each to get updated information about services.*

Resource/Agency	Contact Name	Phone Number

*Add the page of Community Resources to the site's Crisis Handbook.

School Observation

Observe around the school using as a guide the sections of the self-study survey on *Crisis Response and Prevention* that you have reviewed.

In making observations, it is important to understand the difference between what is happening and how well it is happening. Therefore, use the following two column format to first describe what is in place and then indicate whether the practice seems to be good and effective.

First: Describe what you see in as straightforward a manner as you can. (Avoid statements that conclude things were good or bad, more or less, etc.)	**Second:** What are your judgments/ conclusions? (Indicate good-bad impressions, etc.)

Worksheet

Making the Case for Improving Crisis Response and Prevention

(1) Make a priority list of all the crisis response and prevention programs that you would like to see your school enhance/develop this year and those you would like to see in place over the next few years.

(2) Outline some major points that could be used to make the case for putting more effort and resources into crisis response and prevention programs.

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